

This electronic thesis or dissertation has been downloaded from the King's Research Portal at <https://kclpure.kcl.ac.uk/portal/>



What is best for the patient : the ethical experiences, reasoning and decision making of nurses

Chaplin, Clifford John

The copyright of this thesis rests with the author and no quotation from it or information derived from it may be published without proper acknowledgement.

END USER LICENCE AGREEMENT



Unless another licence is stated on the immediately following page this work is licensed

under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International

licence. <https://creativecommons.org/licenses/by-nc-nd/4.0/>

You are free to copy, distribute and transmit the work

Under the following conditions:

- Attribution: You must attribute the work in the manner specified by the author (but not in any way that suggests that they endorse you or your use of the work).
- Non Commercial: You may not use this work for commercial purposes.
- No Derivative Works - You may not alter, transform, or build upon this work.

Any of these conditions can be waived if you receive permission from the author. Your fair dealings and other rights are in no way affected by the above.

Take down policy

If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

**WHAT IS BEST FOR THE
PATIENT:
THE ETHICAL EXPERIENCES,
REASONING AND DECISION-
MAKING OF NURSES**

CLIFFORD JOHN CHAPLIN

PhD thesis – submitted February, 2002

King's College London
University of London



ABSTRACT

This study explores the ethical experiences, reasoning and decision-making of nurses practising on a cardio-thoracic surgical ward. Ethnographic methods, primarily the ethnographic interview, are used to gather data. The data is analysed using both coding and narrative analysis methods. Narrative analysis is conducted using poetic representation.

Findings indicate the complexity of the practice environment. Several factors influencing its ethical nature are identified including: professional relations between nurses and doctors and within nursing, professional power and hierarchical decision-making, staff shortages and heavy workloads, and a culture of blame. Nurses experience frustration when environmental factors constrain their ethical practice. Nurses are ethically sensitive, and experience a variety of ethical events, issues and dilemmas. Three substantive issues are identified as being of particular ethical concern: late cancellation of patient surgery, patient discharge and planning, and resuscitation.

The ethical reasoning of nurses in this study includes styles of thinking found in different philosophies, used in a mutually complementary and supportive way. They use a patient-centred, relationship-based form of ethical reasoning which, combined with emotional involvement, empathy, and concern for beneficence and non-maleficence, suggests an ethic of care approach. Teleological thinking (to act in patients' best interests), deontological thinking (having a duty of care), and the application of ethical principles, are all also evident. Patient-centred ethical concerns such as truthfulness and trust, patient autonomy and agreement, justice, confidentiality, and rights, are also considered important. The identification of personal qualities important in the functioning of the nursing team, or in the process of ethical reasoning and decision-making, is suggestive of virtue theory. Nurses are seen as ethically empowered and at liberty to make ethical choices. As such they contribute to, and are partially responsible for, the ethical nature of the practice environment.

The implications of the findings are considered with respect to knowledge, education, professional practice and future research.

ACKNOWLEDGEMENTS

In presenting this study I would like to acknowledge and give thanks to the following:

The nurses who took part, without whom this study would not have been possible. In particular I am grateful for their openness and honesty in talking about what were on occasions distressing ethical experiences.

My family and friends for their continued interest and encouragement.

My colleagues for their continued support.

My employer, City University, for granting sabbatical leave and for giving helpful financial support.

My supervisor, Alan Cribb, for his good advice and guidance.

TABLE OF CONTENTS

TITLE PAGE	1
ABSTRACT	2
ACKNOWLEDGEMENTS	4
INDEX OF CONTENTS	5
INTRODUCTION	10
 CHAPTER ONE – THE ETHICAL REASONING AND DECISION-MAKING OF NURSES – THE PRESENT STATE OF OUR KNOWLEDGE	 12
DOMINANT THEORETICAL FRAMEWORKS	12
Teleology	13
Deontology	15
Rights Theory	19
Ethical Principles	21
ALTERNATIVE THEORETICAL FRAMEWORKS	23
Virtue Theory	23
Ethic of Care	26
Casuistry	30
NURSING RESEARCH	31
JUSTIFICATION FOR STUDY	34
AIM, OBJECTIVES AND RESEARCH QUESTION	35
 CHAPTER TWO – METHODOLOGY	 37
THE HISTORY AND PHILOSOPHY OF ETHNOGRAPHY	37
Ethnography – a definition and historical background	37
Positivism	39
Naturalism	40
Why ethnography?	42
THE SETTING	42
DATA COLLECTION	43
Interviews	43
<i>The use of semi-structured interviews</i>	43
<i>Rapport</i>	44
<i>Sampling</i>	45
<i>The interview venue</i>	45
<i>The interview process</i>	47
<i>The initial stages</i>	47
<i>Questioning</i>	49
<i>Terminating the interview</i>	50
<i>Audio-tape recording</i>	51
Observational methods	51
DATA ANALYSIS	53
Coding	53

<i>Coding – a definition</i>	54
<i>Open coding – becoming familiar with the data</i>	54
<i>Eliciting meanings and understandings</i>	55
<i>Categorising and the naming of categories</i>	55
<i>Axial coding – making connections between categories and sub-categories</i>	56
<i>Selective coding – identifying the core category</i>	57
<i>Problems with coding</i>	57
<i>Reflexivity</i>	58
<i>Developing theoretical sensitivity</i>	59
<i>Advantages and disadvantages of coding</i>	59
Narrative analysis	60
<i>Selecting sections of narrative</i>	61
<i>Choosing a method of narrative analysis</i>	61
<i>The use of poetry</i>	61
<i>Method of poetic analysis</i>	63
<i>Poetic representation and findings</i>	64
WRITING UP	64
Continuing the analysis	65
Aims in writing up	65
Guidelines for creative writing	66
RELIABILITY, VALIDITY AND REPRESENTIVITY	67
ETHICAL CONSIDERATIONS	70
Worthiness of the project	70
Respect	70
Confidentiality	72
Possible harm and benefits	72
CHAPTER THREE – THE UNETHICAL ENVIRONMENT	74
ETHICAL SENSITIVITY AND TYPES OF ETHICAL EXPERIENCE	75
Ethical sensitivity	75
Types of ethical experience – ethical events, issues and dilemmas	76
PROFESSIONAL RELATIONS BETWEEN NURSES AND DOCTORS	78
Professional power and hierarchical decision-making	78
<i>Prescribing patient medications</i>	79
<i>Care of patients' wounds</i>	82
<i>Reluctance of doctors to consult other specialists</i>	85
Professional communications	89
<i>Ward-rounds</i>	91
<i>'Them and us'</i>	94
PROFESSIONAL RELATIONS WITHIN NURSING	96
Lack of professional support	97
<i>Nurse management</i>	97
<i>The nurse in charge</i>	98
<i>Ill-treatment of new nurses</i>	101
Communication problems	104
BEING SHORT-STAFFED AND HAVING HEAVY WORKLOADS	106

An ethical dilemma	106
Standards of care and priority setting	108
Assuming a pivotal role increased workloads	111
Stress and low morale	112
EXPERIENCES OF BLAME AND FEELINGS OF FRUSTRATION	116
A culture of blame	116
The frustration of nursing	119
CHAPTER SUMMARY AND CONCLUSION	121
CHAPTER FOUR – THREE SUBSTANTIVE ETHICAL ISSUES	124
LATE CANCELLATION OF PATIENT SURGERY	124
Cause of the ethical issue	125
Ethical nature of the issue	126
<i>Harmful and distressing to patients</i>	127
<i>Harmful to the nurse/patient relationship</i>	128
The response of nurses	131
<i>Informing and supporting patients</i>	131
<i>Empathetic understanding</i>	134
<i>Warning patients in advance</i>	135
Summary	136
PATIENT DISCHARGE AND PLANNING	137
Cause of the ethical issue	137
Ethical nature of the issue	139
The response of nurses	142
Summary	145
RESUSCITATION	146
First example – the possibility of having to attempt to resuscitate a terminally ill patient	147
Second example – nurses had to resuscitate a terminally ill man because doctors would not document their DNAR order	150
Third example – the patient who did not want to be resuscitated	155
Summary	157
CHAPTER SUMMARY AND CONCLUSION	157
CHAPTER FIVE – ETHICAL REASONING AND DECISION-MAKING	159
THE IMPORTANCE OF THE NURSE-PATIENT RELATIONSHIP	159
Features characteristic of relationship-based ethical reasoning and decision-making	160
<i>Beneficence and non-maleficence</i>	160
<i>Emotional involvement</i>	162
<i>Empathetic insight</i>	165
<i>The Golden Rule</i>	167
<i>A duty of care</i>	170
Specific patient-centred concerns	172
<i>Truthfulness and trust</i>	172
<i>Autonomy and agreement</i>	174

<i>Just treatment</i>	178
<i>Confidentiality</i>	179
<i>Rights</i>	181
Summary	183
THE IMPORTANCE OF CHARACTER AND VIRTUES, AND THE ROLE OF CONSCIENCE AND GUILT	184
Virtues valuable to the nursing team	185
<i>Being approachable</i>	186
<i>Being supportive</i>	189
<i>Being encouraging to others</i>	191
<i>Being a good role model</i>	193
Virtues valuable in the ethical reasoning and decision-making of nurses	194
<i>Courage and fortitude</i>	194
<i>Experience and confidence</i>	195
<i>Clinical skill and credibility</i>	198
<i>Being questioning and reflective</i>	198
Conscience and guilt	200
<i>Conscience</i>	200
<i>Guilt</i>	203
Summary	206
CHAPTER CONCLUSION	206
 CHAPTER SIX – NARRATIVE ANALYSIS	 208
GERRI'S NARRATIVE – doctors would not write a DNAR order on a dying woman	208
Commentary	215
<i>The ethical incident</i>	215
<i>Gerri's ethical reasoning and decision-making</i>	215
SALLY'S NARRATIVE – the unexpected death of a young patient	218
Commentary	230
<i>The ethical incident</i>	230
<i>Sally's ethical reasoning and decision-making</i>	230
TINA'S NARRATIVE – a patient is misinformed regarding her diagnosis and prognosis	233
Commentary	239
<i>The ethical incident</i>	239
<i>Tina's ethical reasoning and decision-making</i>	240
Chapter summary and conclusion	241
 CHAPTER SEVEN – UNDERSTANDING THE ETHICAL EXPERIENCES, REASONING AND DECISION-MAKING OF NURSES	 244
ENVIRONMENTAL FACTORS AND AGENCY	244
Environmental factors	245
Agency	249
PHILOSOPHICAL DIFFERENCES WITH DOCTORS	252
Ethical differences	253
Ontological differences	255
Epistemological differences	256

ETHICAL REASONING AND DECISION-MAKING	260
CONCLUSIONS AND IMPLICATIONS	266
Knowledge	266
Education	268
Professional practice	269
Research	270
Review of the aim, objectives and research question	271
REFERENCES	272
APPENDICES	286
Appendix 1 Participants	287
Appendix 2 Glossary of abbreviations and terms used by nurses	288
Appendix 3 Semi-structured, focused interview schedule	290
Appendix 4 Consent form	291
Appendix 5 Information leaflet	292
Appendix 6 Research notification	293
Appendix 7 Example to illustrate open coding and initial categorising using Winny's interview transcription	294
Appendix 8 Example of a categorised composite	296
Appendix 9 Diagram to show categories and sub-categories	299
Appendix 10 Summary of categories, sub-categories and their dimensional profiles	300
Appendix 11 Illustrative example of narrative analysis	306
Appendix 12 Diagram to show the ethical experiences, reasoning and decision-making of nurses	320

INTRODUCTION

Before proceeding with the presentation of this research it is necessary to make some introductory comments. The focus of this study is the ethical reasoning of nurses. However, through my research I have endeavoured to set their ethical reasoning within the context in which it took place, in this case in a cardio-thoracic surgical ward setting. Hence, while this study is primarily about the ethical reasoning of nurses, it is also concerned with their ethical experiences and the ethical nature of their practice environment.

I also want to emphasise that while the focus of this study is the ethical reasoning of nurses, it also concerns their ethical decision-making. Indeed, the two are closely linked and throughout my research I have referred to the “ethical reasoning and decision-making” of nurses. However, it has been my intention to discuss the ethical decision-making of nurses, and their practice environment, only to the extent that it helps us understand their ethical reasoning.

The structure of this study reflects this emphasis and content. Chapter one explores the present state of our knowledge regarding the ethical reasoning and decision-making of nurses. Chapter two discusses the methodology used. Chapters three to five outline the findings resulting from the coding analysis and examines: the ethical nature of the practice environment and some of the ethical experiences of nurses, the ethical experiences of nurses regarding three substantive ethical issues, and the ethical reasoning and decision-making of nurses, respectively. Chapter six presents the results of the narrative analysis. The final chapter brings the study to a conclusion by exploring how it has contributed to our understanding of the ethical experiences, reasoning and decision-making of nurses, and its implications.

There are three further introductory points. First, I have gone to great lengths to maintain confidentiality. The names of nurses, patients, other professionals, institutions, and locations, together with any identifying information have been replaced, deleted or altered. All names used, for example, those of nurses or patients,

are pseudonyms. For a list of pseudonymous nurse participants together with details indicating their rank and experience see **appendix 1**. Secondly, in their conversations nurses often used terms and abbreviations the reader may be unfamiliar with. To assist the reader, **appendix 2** consists of a glossary of such abbreviations and terms together with an explanation of their meaning.

Finally, the first part of the title of this study, 'WHAT IS BEST FOR THE PATIENT' is a quotation from one of the nurse participants.

CHAPTER ONE

THE ETHICAL REASONING AND DECISION-MAKING OF NURSES – THE PRESENT STATE OF OUR KNOWLEDGE

The purposes of this chapter is to review the nursing and related theoretical and research literature in order to ascertain the present state of our knowledge regarding the ethical reasoning and decision-making of nurses. In much of the literature, ethical theory is discussed in an ideal or theoretical way. Certain ethical theories are reviewed so as to suggest their usefulness or appropriateness, but not from the perspective that nurses or other health care professionals do think in this or that particular way. As a consequence much of the literature fails to inform us of the way in which nurses ethically reason and make decisions, or of the contextual or environmental influences on their thinking.

Nevertheless, an examination of the literature does inform us of the dominant and alternative theoretical frameworks used to characterise, at least theoretically, ethical reasoning and decision-making. In this chapter the dominant traditional philosophical frameworks found in the literature will be critically explored. Other philosophical frameworks found in the literature, which are often presented as alternatives to traditional frameworks will also be critically examined.

It is anticipated that such a review will demonstrate the need for this study. This chapter will also review the current state of nursing research into the ethical reasoning and decision-making of nurses, and will conclude with a justification for this study together with a statement of its aim, objectives and research question.

DOMINANT THEORETICAL FRAMEWORKS

The dominant theoretical frameworks of teleology, deontology, rights theory and the application of ethical principles are commonly mentioned in the literature and require critical attention. In much of the health care ethics literature, whether it be on the general

subject of bioethics (e.g. Mappes and DeGrazia, 2001; Seedhouse, 1998; Beauchamp and Walters, 1999), or specifically on nursing ethics (e.g. Thompson et al. 2000; Johnstone, 1999; Rumbold, 1999), the philosophical traditions of teleology (primarily utilitarianism) and deontology are contrasted and applied. I will commence this survey of the literature with a critical analysis of these two traditions, and comment on their usefulness with regard to the ethical reasoning and decision-making of nurses.

Teleology

Teleological theory claims that the rightness or wrongness of actions is exclusively a function of the goodness or badness of the consequences resulting directly or indirectly from the action (Mappes and DeGrazia, 2001). Simply put, teleology holds that the moral worth of an action is dependent on the consequences resulting from it. If the outcome of an action is good the action may be morally justified. If, on the other hand, the outcome of an action is bad the action is not morally justified.

The most well known form of teleological theory is utilitarianism. Bentham (1990:9), the founder of modern utilitarianism, points out that it is based on the principle of utility and the philosophical assumption that mankind is governed by "... two sovereign masters, pain and pleasure." The principle of utility, according to Bentham (1990:10), "approves" or "disapproves" of every action according to its tendency to "augment" or "diminish" the "happiness" of, or prevent the pain of, the individual or community. Mill (1990:61) describes the principle of utility as the "Greatest Happiness Principle" and explains that it holds that actions are right in proportion to their promotion of happiness, and wrong in proportion to their promotion of pain. According to Mill (1990:61), "pleasure" and "freedom from pain" are "... the only things desirable as ends."

A number of specific forms of utilitarianism have emerged. Two are worthy of particular note, namely act and rule utilitarianism. According to Mappes and DeGrazia (2001:8) act-utilitarianism is where "... a person ought to act so as to produce the greatest balance of good over evil, everyone considered." That is, when faced with moral choice a person is required to consider the likely consequences to all involved and take the action that will produce the greatest degree of good (happiness or pleasure) over evil (pain or unhappiness). The interests of everyone are deserving of consideration. It is a form of

situational ethics where there are no intrinsically wrong actions. Indeed, certain actions such as stealing and lying may be wrong in some situations but right in others. The context or situation is of moral relevance and must be taken into account when considering what action to take.

Rule-utilitarianism differs from act-utilitarianism in that it emphasises the use of moral rules derived from the principle of utility. According to Mappes and DeGrazia (2001:13) rule-utilitarianism is where "... a person ought to act in accordance with the rule that, if generally followed, would produce the greatest balance of good over evil, everyone considered." That is, when faced with moral choice a person is required to consider rules formulated on the basis of the principle of utility and then to apply such rules to the situation at hand. Unlike act-utilitarianism it is a two-stage rather than a one-stage process. For the rule-utilitarian a person has acted morally if in accordance with utility based rules, though in extreme circumstances exceptions are permitted. For example, the utilitarian rule of not breaking professional confidentiality, which is based on the utilitarian premise of maximising social happiness, may be broken in the public interest, as in the case of preventing harm to others.

Utilitarianism is much criticised. It suffers from the problems inherent in teleological theory. Ethical reasoning and decision-making that depends solely on the assessment of consequences is problematic because consequences can be unpredictable, and it is difficult to estimate all the consequences arising from an action. It is suggested that the only consequences that should be taken into account are those that are reasonably foreseeable (Ayer, 1990:50). An emphasis on consequences also suggests that teleology may be seen as a theory where the ends justify the means. Additionally, teleology takes no account of the motive behind human action. As a result, actions guided by an immoral motive may be justified if they achieve good consequences, and actions taken with good motive may be condemned as immoral on the basis of surprising and unexpected consequences.

Both act and rule utilitarianism face a number of well-known additional criticisms. Act-utilitarianism is seen as setting an overly demanding moral standard by insisting that the aim of all actions is to maximise happiness, and that such actions should take into account everyone affected (Mappes and DeGrazia, 2001:11). Act-utilitarianism fails to

take into account the natural tendency of personal prudence, and overlooks the importance of morally significant relationships and one's obligations to, for example, relatives and friends. Additionally, in the quest to maximise general happiness the rights of individuals may be ignored and so act-utilitarianism does not accord with our conviction that individuals have rights (Mappes and DeGrazia, 2001:11-12). Rule-utilitarianism fares little better, though it is considered that it is more reconcilable with our experience of the morality of everyday life in that it presents a less demanding moral standard and respects the importance of morally significant human relations (Mappes and DeGrazia, 2001:16). However, it remains open to allegations that it opposes the notion of individual rights, and can lead to individual injustice in the general quest to maximise happiness. Indeed, some critics argue that rule-utilitarianism eventually collapses into act-utilitarianism as, for example, when dilemmas arise that involve conflict among moral rules (Beauchamp and Walters, 1999:13).

Johnstone (1999:85-6) offers a word of caution against the use of the hedonistic utilitarianism of Bentham and Mill in nursing ethics and models of moral decision-making, principally because of its inadequacy in "objectively" determining right and wrong. Nevertheless, utilitarianism appeals to nurses and other health care professionals as their aim is to prevent or relieve pain and to promote the health and well being of patients (Thompson et al. 2000:316). Indeed, Thompson et al. (2000:316) point out that while it does not provide easy answers to questions about the nature of health, happiness, and quality of life, health care professionals find its teleological nature appealing as they need to assess the consequences of treatment and planned care.

Deontology

Deontology differs fundamentally from teleology in that it holds that duty, and not consequences, is the primary moral consideration. Several forms of deontology are mentioned in the literature. Johnstone (1999:73-81), for example, when discussing deontology includes theological ethics, rationalism, emotivism, intuitionism, and social contract theory. Two forms of deontology most frequently identified are act-deontology and rule-deontology. Act-deontology opposes the following of rules and holds that the individual can, by rational introspection, determine his or her moral duty. Each situation is considered as different, and actions are right if based on pure motive, good intentions,

and adherence to one's perceptions of personal duty. Act-deontology is, according to Thompson et al. (2000:301), indistinguishable from intuitionism. Seedhouse (1998:115-16) points to advantages and disadvantages of this form of deontology. While it obliges one to be true to oneself and not to follow rules blindly, it appears impractical in modern health care practice where rules to guide professionals in complex situations are considered necessary. Rule-deontology, on the other hand, asserts that moral rules or duties, which should be followed irrespective of the likely outcome, should guide an individual's actions. This form of deontology has the advantage of providing a guide to action, particularly when formulated into codes of professional practice. However, it is problematic when to follow the rule leads to undesirable consequences, or when rules conflict (Seedhouse, 1998:116-17).

Kantian deontology is the most prominent and influential form of rule-deontology. Like all forms of deontology, it stands in stark contrast to utilitarianism because its central concerns include the motive of the individual. Kant (1948:63), in fact, refers to the "motive of duty". He objects to a teleological morality based on the principle of personal happiness. Kant (1948:103) considers the idea that well-being necessarily adjusts itself to well-doing is contradicted by experience, that making a man happy is different from making him good, that morality is undermined if based on sensuous motives, and that such a morality reduces virtue to the same level as vice.

Kant (1948:59) argues for a morality based on "good will", the only thing, he asserts, that can be taken as good without qualification. For Kant, moral goodness is good will determined by reason and expressed in terms of duty. But reason, the guiding force of good will, itself requires guidance. This guidance, Kant argues, is to be found in the concept of a universal law of nature, to which personal will is subordinate. On the basis of this argument Kant (1948:80) formulates the "categorical imperative", which he describes as a "... command... being absolutely, although practically, necessary." Kant develops a number of formulations for the categorical imperative. Two are often cited in health care ethics literature. The first reads, "Act only on that maxim through which you can at the same time will that it should become a universal law" (Kant, 1948:84). This implies that one's moral action should be guided by considering whether one could will the rule behind a proposed action to become a universal law of nature. Mappes and DeGrazia (2001:18) point out that this formulation has often been

compared to the Golden Rule, though in fact it is distinctly different, while Thompson et al. (2000:17) emphasise the importance of the principle of reciprocity in Kant's philosophy.

The second formulation of the categorical imperative often cited reads, "Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end" (Kant, 1948:91). This formulation is of immediate appeal in health care ethics because it represents Kant's philosophy as one of respect for people. It implies that we should always act towards ourselves and others with respect. Such respect is based on the assumption that all rational persons have the capacity to reason and to act morally. It is a directive suggesting that, while we may all use each other as a means to certain ends, we should never treat others simply as a means to an end.

The principle of respect for autonomy is a key component in Kant's moral philosophy. Kant (1948:93) refers to the "formula of autonomy" whereby all rational beings are subject to the universal law of nature but at the same time create universal law. Kant (1948:108) argues that a free will and a will under moral laws amount to the same thing. Furthermore, the principle of the autonomy of the will is considered by Kant (1948:94) to be "unconditioned" in that actions are not based on the necessity of acting out of certain interests, either of self or others. Unlike the doctrine of heteronomy, where actions are based on certain interests, one's own or another's, and are therefore conditioned, according to the principle of autonomy, actions are based on no other end than the will itself. For Kant (1948:94) man "... is subject only to *laws which are made by himself* and yet are *universal*, and that he is bound only to act in conformity with a will which is his own but has as nature's purpose for it the function of making universal law." Such a position gives rise to what may be described as a sort of moral utopia, which Kant (1948:95) calls the "kingdom of ends".

Kant's deontology is much criticised. His concept of duty has long been seen as impractical. Hegel (1967:90) argues that because Kant's definition of duty is based on the absence of contradictions, it fails to provide criteria for the determination of duty, and as a result is simply "empty formalism" and the "... reduction of the science of morals to

the preaching of duty for duty's sake." In the health care context, according to Singleton and McLaren (1995:18-19), Kant fails to give a descriptive enough method of dealing with situations where duties clash, though they concede this may not be possible anyway. Seedhouse (1998:122) also raises this problem and points out that it may be difficult in a world of limited resources to treat all people as "ends", and Kant offers no criteria by which decisions can be made about who should be treated as "ends" when not everyone can. In fact, Kant does provide an elaborate classification of perfect and imperfect duties but this too is criticised, not least for understating the importance of the duty of beneficence (Mappes and DeGrazia, 2001:23).

Seedhouse (1998:121) refers to problems with unyielding imperatives in the complex world of health care where compromise is sometimes called for and where appropriate moral action may involve an exception to the rule. Indeed, while the absolutism implied in Kant's "imperative" may lead to confident, even courageous acts under the conviction of being right, they may also lead to rigidity, intolerance and self-righteousness (Thompson et al. 2000:301). As with other forms of deontology, Kant's emphasis on duty and undervaluation of consequences is also criticised (Rumbold, 1999:74). Seedhouse (1998:123) points out that it is no legal or moral defence to say that an action was done out of a pure motive to be moral, and warns health carers that they ignore at their peril Kant's underemphasis on consequences. Other criticisms of Kantian deontology, such as its over reliance on reason, its denial of the importance of other virtues, its acontextualism, and its assumed impartiality and universalism will be referred to at various points later in this chapter. Finally, Edwards (1996:37) questions if the commonsense view of morality that influenced Kant in his formulation of the "categorical imperative" in eighteenth century Europe still applies today.

Despite criticism, Kant's deontology is seen as having some advantages. Mappes and DeGrazia (2001:22) argue that Kant's "categorical imperative" successfully accounts for important aspects of our experience of moral life. It provides clear injunctions against immoral acts, such as killing, injuring, lying, and breaking promises, and it is in accord with our conviction that the end does not justify the means. In health care the notion of duty is seen as important. Nurses are familiar with the language of duty, 'going on duty', and 'having a duty of care', are familiar terms. For nurses and other health care professionals a compelling feature of deontology is that it places respect for people at the

core of morality (Mappes and DeGrazia, 2001:22), and emphasises the importance of obligations to others (Thompson et al. 2000:301). Callender (1998) argues that by linking free will, rationality, and ethics into a single philosophical system Kant offers a theoretical framework for psychotherapy. Additionally, Kant's concepts of universalisability and "ends in themselves" are important to health carers because they afford all people equal status as moral agents and deserving of equal respect (Seedhouse, 1998:123). As such, Kant lays the basis for justice, equality and equal treatment and, together with the concept of duty itself, provides a secure foundation for the notion of individual rights (Mappes and DeGrazia, 2001:22).

Rights Theory

The theory of rights is popular and influential in the philosophy and politics of western cultures (Johnstone, 1999) and is often used in health care ethics. Beauchamp and Childress (2001:357) define rights as "... justified claims that individuals and groups can make upon other individuals or upon society." One of the most important aspects of rights theory is that it helps define the duties individuals have to others. Much of the literature makes a distinction between different categories of rights, for example, those that are legal and institutional, universal moral, and special moral (Thompson et al. 2000:135). Numerous rights applicable in health care are identified. Thompson et al. (2000:141), for example, identifies patients' rights to know, to privacy, and to treatment. Whereas Johnstone (1999:97-8) refers to the right to health care, to make informed decisions, to confidentiality, to dignity and dying with dignity, and to be treated with respect. In much of the literature the discussion of rights is linked to the principle of autonomy. Beauchamp and Childress (2001:356), for example, discuss rights within the context of "liberal individualism". Singleton and McLaren (1995:141) argue that the current relevance of rights in health care is related to the rise of consumerism and the perceived need to protect personal autonomy against the paternalism of health care professionals.

An analysis of the theory of rights reveals that it has both advantages and disadvantages. With respect to the disadvantages, a number are mentioned in the literature. One of the main criticisms is that rights can clash. With regards to the issue of abortion, for example, the 'rights' of the unborn child clash with the 'rights' of the woman. In such

circumstances the theory of rights is unable to provide a resolution but perpetuates the impasse. It is also argued that the language of rights is unnecessarily adversarial in certain circumstances. Beauchamp and Childress (2001:361), for example, argue that while children's rights may provide vital protection against abuse, the notion that the child has claims against the parents is an inadequate framework to express the moral nature of the parent-child relationship. Another difficulty is that the theory of rights does not provide an absolute answer to the question of what entities have rights. According to rights theory human beings have rights, but what of the rights of other entities such as animals and even forests? Additionally, rights theory does not necessarily inform us of the degree to which the entitlement of rights extends amongst humans? What, for example, are the rights of the unborn child, the anencephalic baby, or indeed the dead? Another problem with the theory of rights is that to claim a right is not necessarily to have it guaranteed. It may, for example, be difficult to satisfy the rights claim of all people in situations of limited resources (Johnstone, 1999:101), and an individual's claim to rights needs to be considered alongside social ideals and principles of obligation (Beauchamp and Childress, 2001:361).

Furthermore, rights theory is often criticised for lacking a firm theoretical foundation on which the claim to specific rights may be made. In fact, a number of theoretical foundations are articulated, such as natural law and divine command, common humanity, rationality, and interests (Johnstone, 1999:97-8). On the issue of the theoretical basis for the existence of rights, Thompson et al. (2000:137) points out that an appeal to rights is based on the general concept of human dignity and presupposes the existence of fundamental moral principles. For example, the right of equal access to health care is based on the principle of justice. Similarly, the rights to know and to privacy are based on the principle of respect of persons. In essence, according to Beauchamp and Childress (2001:361), rights theory is an incomplete theory that provides minimal and enforceable rules that communities and individuals must observe in their treatment of others.

Despite disadvantages, the theory of rights is seen as having a number of advantages, both in general, and in the health care context. First, it empowers and gives a voice to the disadvantaged, minorities, and those suffering forms of abuse and exploitation that have justifiable claims, and provides a mechanism for claiming their rights. As Beauchamp

and Childress (2001:362) put it, the language of rights protects the legitimate interests of citizens. Rumbold (1999:80) argues that the increasing acceptance of the right to health care has motivated the removal of inequalities. Secondly, it provides a mechanism for the identification of both positive and negative duties and as such sets positive standards of behaviour. The Patient's Charter (1992), for example, outlines certain rights to which consumers of health care are entitled, and stimulates health care professionals to respect those rights. In general, rights are acknowledged as international standards for the treatment of persons (Beauchamp and Childress, 2001:362).

Ethical Principles

Another popular approach to health care ethics, and one widely mentioned in the literature, is the application of ethical principles. The most influential example of this approach is that of Beauchamp and Childress (2001) as articulated in their text 'Principles of Biomedical Ethics', and it is their approach that I will concentrate on. I will refer to it as 'principlism', though Clouser and Gert (1990) first used the term as a form of criticism. In essence Beauchamp and Childress (2001) propose the four principles of respect for autonomy, beneficence, non-maleficence, and justice, together with certain derivative rules, notably truthfulness, privacy, confidentiality and fidelity as a framework for identifying, analysing and resolving moral problems in medicine (Childress, 1997).

A notable application of ethical principles in nursing is that of Edwards (1996) in the publication 'Nursing Ethics: A Principle-Based Approach'. Edwards (1996:49) argues that the main advantage of principlism is the provision of conceptual tools that may be used to structure one's moral intuitions. Edwards (1996) proposes that level three principles, as opposed to level one judgements, level two rules, and level four theories, are most applicable in nursing ethics. According to Edwards (1996:48), principles are easily applied to ethical problems faced by nurses and they encourage nurses to consider ethical problems from the different perspective of each principle. Theories, Edwards (1996:48-9) believes, promote the erroneous view that there are easy solutions and therefore encourage a simplistic view of ethical situations. Edwards (1996:49) concludes that nurses find principles easy to apply, their use allows nurses to develop a coherent, well-motivated strategy, and nurses are obliged

to consider principles in order to fulfil their professional obligations as principles such as respect for autonomy are included in the Code of Professional Conduct (UKCC, 1992).

Principlism is much criticised. While Edwards (1994) sees the simplicity of principlism as one of its advantages, one of the main criticisms is that the use of principles as a means to address ethical questions is too simplistic. While they provide an easy to understand ethical system for nurses and other health care practitioners, their use is misleading both practically and theoretically (Clouser and Gert, 1990:219). With regard to practice, principles fail to act as guides to action because there is no systematic relationship between them. They lack specification and balancing and are, as a result, morally inert (Holm, 1995a:336). Principles often clash, and when they do there is no clear direction for moral action. As a result moral conflict remains unresolved while there is disagreement about which principle predominates and under which circumstances. Edwards (1996), for example, argues that the principle of respect for autonomy is the “weightier”, whereas Holm (1995a) believes that there is an over-emphasis on the principle of respect for autonomy and an underdevelopment of the principles of beneficence and justice. From a theoretical perspective, while Edwards (1994) sees advantages in focussing at the level of principles, critics of principlism argue that ethical problems need to be addressed at the higher level of theory. Otherwise discussion is reduced to mere formalised statements of existing ideas and individual prejudices (Holm, 1994:16). There is concern that an emphasis on principles over theory may deny real scope for personal judgement in ethics and lead to “tyrannical absolutism” (Toulmin, 1981:31).

Another criticism of principlism is related to its nature as a “common morality theory” (Holm, 1995a:332). The principlism of Beauchamp and Childress (2001) has its origins in America and has been popularised in Europe by Gillon (1986, 1994). Yet there is concern that it reflects the society and culture in which it originated and may not be transferable to other cultures and societies (Holm, 1995a:333). There is particular concern that it reflects an American emphasis on autonomy over beneficence and justice, a paradigm that does not fit comfortably within the European cultural context (Holm, 1995a:333). In defence of principlism, Gillon (1994) has introduced the notion of “scope” of application and has done much in an attempt to show that the four principles

may be applied in many different cultural and religious traditions. One of the basic criticisms of principlism is that it lacks the benefits of a single unified moral theory that would provide a "... single clear, coherent, and comprehensive decision procedure for arriving at answers" (Clouser and Gert, 1990:233). This may well be an unrealistic expectation. Perhaps the best we can hope for in any common morality theory, as principlists suggest, is a set of general principles that may be applied taking into account the specific circumstances of the situation and context.

Finally, even one of the most ardent critics of the principlism of Beauchamp and Childress (2001) recognises that wide distribution of their seminal work amongst health care practitioners has led to significant improvements in patient care (Holm, 1994:12). The crucial point in the discussion about the usefulness of principles concerns their mode of application in ethical decision-making. Dogmatic application may well give rise to a morality that is tyrannical and disproportioned (Toulmin, 1981:37). However, defenders of principlism argue this is not the intention. Practical application of principles requires cultural sensitivity, an understanding of casuistry and the application of principles in specific cases, and an understanding of other theoretical perspectives such as virtue theory (Gillon, 1995:324).

ALTERNATIVE THEORETICAL FRAMEWORKS

Having critically discussed some of the dominant theoretical frameworks, I wish now to examine some of the alternative theoretical frameworks found in the nursing and related literature. Three, namely, virtue theory, the ethic of care, and casuistry are popularly referred to and require examination.

Virtue Theory

There has in recent years been a resurgence of interest in virtue theory (Johnstone, 1999:103). This interest is in response to dissatisfaction with action-based moral theories and the principles resulting from them. As we have seen principlism is criticised. Mappes and DeGrazia (2001:29) point out that principles are sometimes of little use in practical ethical decision-making as they are too abstract, sometimes clash, and take little account of the fact that we often morally judge peoples' motivations and character, not

just their actions. According to Scott (1995:283) moral theories that concentrate on moral action, and fail to focus on character and motivation, portray a minimalist conception of the moral dimension of health care practice. Lützén and Barbosa da Silva (1996:202) hypothesise a need for both duty-based ethics as well as an ethics of virtue and character as they complement one another and neither by itself is sufficient.

While the principle concern of action-based moral theory is with determining the right thing to do, the principle concern of virtue theory is with what kind of person to be (Mappes and DeGrazia, 2001:28). Virtue theory has its origins in Greek philosophy, mainly that of Aristotle, and requires the personal cultivation of virtues and moral motive. In fact, Aristotle (1953:54) defines virtues as those “dispositions” of a person’s character that are praised. Aristotle makes a distinction between intellectual virtues such as wisdom, intelligence and prudence, and the moral virtues such as liberality and temperance (MacIntyre, 1966:64). The two types of virtues are distinguished by the ways in which they are acquired. The first is acquired through instruction and the second through habitual exercise. The two types of virtues are closely related. The use of practical intelligence is necessary in the perfection of moral virtues, and moral virtues are required in the exercise of practical intelligence less it “... degenerates into or remains from the outset merely a certain cunning capacity for linking means to any end rather than to those ends which are genuine goods for man” (MacIntyre, 1985:154).

Beauchamp and Childress (2001:28) refer to the special status of virtues and find attractive the idea that the language of obligation is derived from the language of virtue, and that a person who by character has good motive and desires provides the model for the moral person and that this model determines obligations. Interestingly, Beauchamp and Childress (1994:66) argue that virtue-based and obligation-based theories are compatible and mutually reinforcing, but appear to somewhat withdraw from this position in the most recent edition of their work. Nevertheless they do, in the most recent edition, emphasise the importance of moral character in a comprehensive vision of moral life by devoting the whole of the second chapter to the subject (Beauchamp and Childress, 2001). They consider that principles such as respect for autonomy, non-maleficence, beneficence, and justice have the corresponding virtues of respectfulness, non-malevolence, benevolence, and justice or fairness (Beauchamp and Childress, 2001:39). Regarding the relationship between principles and virtues, not all virtues need

to correspond with respective principles. May (1994:78-9) refers to two types of moral challenge that require virtues. The first concerns the question of what to do about something, which may require virtues that correspond to principles that are orientated towards some sort of action in dealing with the problem. The second moral challenge may concern the question of how to behave towards something, and require virtues needed, not to deal with a specific moral problem, but to face certain difficulties in life such as the death of a loved one.

It is argued that one's sense of duty is likely to fail if not backed up by personal virtue (Scott, 1995:280). Lützén and Barbosa da Silva (1996) explore the role of virtue ethics in psychiatric nursing and point out that both intellectual and moral virtues are necessary for the realisation of duties and moral obligations, and that virtues assist in making choices between conflicting principles. They also point out that it is important to be concerned with motive and to make a distinction between the nurse who simply follows the rules and the nurse who is motivated by affection for the patient. Put simply, doing right does not always mean the motivation is to do good (Lützén and Barbosa da Silva, 1996:203-4). It can be argued that moral theory is more complete if virtues and moral motive are included (Beauchamp and Walters, 1999:16).

Despite its apparent advantages, virtue theory is criticised. Johnstone (1999) refers to the "circularity of justification" with respect to it, i.e. the argument that virtuous people do what is good, good is what virtuous people do. Lützén and Barbosa da Silva (1996:209) also point to the difficulty of determining what is virtuousness and point out that virtues depend on how roles and responsibilities are perceived. If, for example, a nurse is considered to be a handmaiden to doctors then virtues of passivity, subservience and obedience may be valued, if on the other hand the nurse is considered to be an advocate, then the virtues of justice and courage may be valued. Virtue theory is also criticised because in comparison with action-based theories it is unable to explain its force as a guide to moral action (Johnstone, 1999:105). In addition, justifying ones ethical reasoning and decision-making by reference to virtue theory and motive, and then transgressing rules, even if the anticipated consequences are considered beneficial to the patient, may be dangerous (Lützén and Barbosa da Silva, 1996:204). Johnstone (1999:105-6) points to the difficulty of virtue theory in that it imposes high expectations on people to be exemplars of good. However, she reasons that it seems odd to suggest

that expecting people to be decent and morally excellent human beings is too high an expectation, as morality is, in fact, about expecting people to attempt to achieve morally excellent conduct.

Despite the criticisms it faces, Aristotelian virtue theory may be useful to nurses and other health care professionals in a number of ways (Scott, 1995:279). The relationship with patients and other health carers is an important part of professional practice. Virtues are beneficial in communication and human interaction, and the character of professionals plays an important part in therapeutic relationships (Scott, 1995:280). Additionally, the belief that virtues and moral sensitivity are acquired through a developmental and learning process implies that virtues considered important to nurses can be learnt, and the notion of habituation suggests that virtuous behaviour can be perfected by repeated practice (Scott, 1995:281-2). Virtue theory also recognises the importance of learning good moral habits by emulating ethically sensitive role models, though bad as well as good habits can be learnt and it is important to differentiate between the two (Scott, 1995:282). Finally, virtue theory recognises the importance of emotions and the need for appropriate emotional responses, this is significant as many virtues considered important in nursing, such as empathy, compassion, and care, have an emotional component (Scott, 1995:283). Such virtues are considered important in the next alternative theoretical framework to be discussed, that known as the ethic of care.

Ethic of Care

The ethic of care approach to ethical reasoning is discussed in much of the current nursing and general ethics literature. Linked to feminist ethics and virtue theory, it arose in response to a perceived failure in traditional moral philosophy to take account of the moral thinking of women. Traditional moral philosophy is considered to be male biased and incomplete, and as such incapable of supplying an adequate moral philosophy (Johnstone, 1999:113). Indeed, it would seem that traditional philosophy and many philosophers including Aristotle, Aquinas, Rousseau and Kant have considered women rationally and morally inferior to men (Johnstone, 1999:116-7).

The development of the ethic of care owes much to Carol Gilligan (1982), who challenges assumptions made by Kohlberg (1981) in his theory of moral development.

Gilligan questions the validity of the research from which Kohlberg formulated his theory of moral development. The research consisted of a longitudinal study of moral development in which the subjects were all males. This, Gilligan claims, means that Kohlberg's findings are inherently biased and can not be generalised to women. Of particular concern is the fact that Kohlberg's hierarchical theoretical progression of moral development, which consists of six stages, places moral qualities and concerns important to women at stages three and four, (stages 1-4 involves non-principled reasoning, and stages 5-6 involves principled reasoning and therefore, according to the theory, represents moral maturity). This is significant because according to Kohlberg's theory those who base their moral judgements on non-principled moral qualities such as relationships and care appear morally immature, whereas those who use universal principles in their moral thinking are deemed morally mature. As Johnstone (1999:118) points out, women are again portrayed as incapable of authoritative moral reasoning. Additionally, as a result of her own research Gilligan (1982) emphasises the importance of affective considerations in the moral reasoning of women, such as relationships, involvement, context, concern, and care. By doing so she challenges Kohlberg's emphasis on impartial, non-contextual Kantian justice as the primary moral position. Regarding the implications of gender differences in her theory, Gilligan (1993:207-214) is at pains to point out that the ethic of care is not biologically determined or unique to women, but that women have a tendency to embrace it and men to embrace the ethic of rights and justice. Gilligan's challenge is significant and has had an important effect on nursing research, something I will return to later.

The concerns Gilligan raises as a result of her empirical research have been supported philosophically and theoretically. Holm (1997:16) points out that other writers have developed the ethic of care to the extent that it is probably inaccurate now to refer to a single ethic of care. Baier (1995:1-17.), who is critical of universal principles and argues that dominant moral theory is incomplete, claims that she sees in the writing of different female philosophers, and some men who she entitles "honorary women", the same concerns raised by Gilligan. In fact, Baier (1999:43) sees in Gilligan's version of moral maturity a challenge to the individualism of the Western tradition with its emphasis on personal autonomy, and the belief in "... the possibility and desirability of each person pursuing his own good in his own way, constrained only by a minimal formal common

good, namely a working legal apparatus that enforces contracts and protects individuals from undue interference by others.”

The ethic of care is criticised in the literature. According to Edwards (1996:133), as a theory it is undeveloped because it does not seem to provide clear guidelines on how to reason and act when faced with difficult ethical situations, it simply makes the descriptive point that care and concern are required. Beauchamp and Childress (2001:374) suggest that while the theory may be undeveloped it is not necessarily incorrect. One of the central features of the ethic of care, its rejection of impartiality, is also questioned on the basis that nurses and other health professionals face many ethical situations, and moral reasoning may require partial or impartial reasoning depending on the situation (Beauchamp and Childress, 2001:374). From the perspective of principlism, Beauchamp and Childress (2001:374-5) question the coherence of the ethic of care perspective when it appears to reject some principles, such as those of Kant, but accepts others, particularly *prima facie* ones.

Some criticism of the ethic of care comes from feminist ethics. The relationship between feminist ethics and the ethics of care is a complex one, and there has been a mixed response from feminists (Mappes and DeGrazia, 2001:32). Some have responded positively to what may be seen as the validation of the moral reasoning and orientation of women. Others point to some difficulties. Sherwin (1992:49-50), for example, calls for caution in determining gender traits within a sexist society, because perceived gender differences may be part of the structure that supports dominance relations, and female proficiency at caring may be related to the subordinate status of women. Friedman (1993) is also cautious, and hypothesises that Gilligan in fact identifies the symbolic female voice and distinguishes it from the symbolic male voice. Classifying justice and caring as representing the moral orientations of men and women respectively may in part be a consequence of cultural myth and gender stereotyping.

Despite the criticisms it faces, ethic of care makes a valuable contribution to our theoretical understanding of moral reasoning. It contributes primarily by making a number of important criticisms of dominant ethical theories. First, the ethic of care challenges the assumption found in many theories including utilitarianism and Kantian deontology that impartiality is a requirement in moral reasoning, and holds that

partiality, which is a dominant feature of the moral reasoning of women, is also important. The importance of family and individual relations and indeed professional relations, as for example, that between nurse and patient, form an important part of our moral existence and are influential in our moral reasoning (Mappes and DeGrazia, 2001:31). Beauchamp and Childress (2001:372) point out that the partiality of the care perspective is meaningful for people in such roles as parent, friend, doctor and nurse where a "... contextual response, attentiveness to subtle clues and deepening special relationships are likely to be more important morally than impartial treatment." Additionally, the abstract impartial nature of dominant theories deny the importance of unique personal and individual experience such as that of being a woman, a patient, a member of an ethnic minority group, and so on.

Secondly, the ethic of care, by giving emotions a moral role, corrects the cognitive bias of philosophers such as Plato and Kant, who saw emotions as an obstruction to rational moral action (Beauchamp and Childress, 2001:373). The nurse who responds to a sick patient in a rule-orientated way without emotions such as compassion and empathy appears to be morally lacking. Thirdly, the ethic of care is critical of the abstract principles and rules of many of the dominant theories, which are considered impractical in the real world and unable to offer clear guides to action. In complex ethical health care situations guidelines such as 'maximise utility' and 'respect people as an end in themselves' provide inadequate guidance (Mappes and DeGrazia, 2001:31). Instead of applying abstract rules or principles, there is, according to the ethic of care, the need for a casuist approach where the context and details of any given ethical situation are closely explored and carefully considered. Abstract principles are also criticised because they tend to ignore the affective aspects of moral life. In response to an elderly terminally ill patient who says she wants to die, it is preferable if the nurse demonstrates compassion and involvement in dealing with the situation rather than applies ethical principles in a detached way.

Finally, the main contribution of the ethic of care is that it enriches our understanding of moral reasoning and decision-making by focusing attention on topics that have been ignored in dominant ethical theory, such as the moral emotions and women's experiences. However, Edwards (1996:138) gives a word of warning by pointing out that claiming a motive of care and concern may not be enough to justify the actions of a

nurse who fails to resuscitate a patient because she reasoned it was the most caring thing to do. Firmer guidelines for ethical practice may be required. Even so, a morality based on an ethic of care with its emphasis on care and concern can potentially serve health care ethics by freeing practitioners from a narrow conception of their role and responsibilities (Beauchamp and Childress, 2001:376).

Casuistry

In our discussion so far, the need for a casuist approach has been referred to in both principlism and the ethic of care approach to ethical reasoning and decision-making. With its origins in medieval philosophy, casuistry has in the past decade become popular (Johnstone, 1999:106), and is discussed in much of the nursing and general ethics literature. Unlike most dominant ethical theory, casuistry concentrates on practical decision-making in particular cases. Sceptical of the use of universal principles and rights, casuists emphasise the need to pay close attention to the unique and particular circumstances of individual cases and to the historical record of similar cases (Beauchamp and Childress, 2001:393).

According to Murray (1994:91), casuistry has gained in popularity in response to the perceived inadequacies of the deductive approach of applying abstract, general moral theory and principles to ethical difficulties in health care. The difficulty of applying such theory and principles encourages inattentiveness to the particularities of cases, and a focus on the unimportant features such that important aspects go unnoticed. In particular, the deductive approach of applying general moral theory and principles pays little attention to social and historical contexts and therefore may fail to realise the importance of particular social circumstances. In contrast to the deductive approach, according to Murray (1994:95-6), casuistry involves a concern for and close examination of individual cases. It is particularly important to closely analyse cases by becoming immersed in their situational particularities such as the social and historical contexts in which they occur (Murray, 1994:96-7).

There are several criticisms of casuistry. While casuistry recognises the limitation of moral theory and principles, the response of casuists to these things varies. Some are critical of theory while others encourage theory construction as well as generalisation

from cases (Beauchamp and Childress, 2001:397). It is suggested that casuistry is a “method without content” (Beauchamp and Childress, 2001:395), and that the concern of casuists for focusing on the case being considered needs to be linked with appropriate theory and principles that control judgements made about the case (Beauchamp and Walters, 1999:18). Additionally, their reliance on historical judgements of similar cases, the doctrine of precedent, is criticised. It is problematic when analogies conflict, and casuistry lacks a methodology that might prevent the development of analogies that are either biased or negligent of important features of cases (Beauchamp and Childress, 2001:395).

Finally, while casuistry may have drawbacks, it is useful to the nurse because it makes a number of contributions to ethical reasoning and decision-making. In particular, it emphasises the importance of the practicalities of ethical decision-making by focusing on the case at hand (Thompson et al. 2000:98), and it emphasises the importance of taking into account the particular contextual and individual circumstances of different cases (Johnstone, 1999:107).

NURSING RESEARCH

Having critically surveyed the principle ethical theories found in the nursing and related literature, the question arises as to what extent such theories are relevant in practice. Do nurses, in fact, employ such theories in their ethical reasoning and decision-making and how useful are they? A survey of the research literature indicates that such questions have been inadequately investigated.

A survey of recent nursing research shows that during the 1980's and early 1990's many studies into the ethical reasoning and decision-making of nurses used Kohlberg's cognitive theory of moral development as a theoretical framework. Measurement tools based on Kohlberg's theory, such as the Moral Judgement Interview developed by Kohlberg (1969), the Defining Issues Test developed by Rest (1986) and the Nursing Dilemma Test developed by Crisham (1981) were designed and commonly used to measure rather than explore the ethical reasoning and decision-making of nurses. This approach was influential and Dierckx de Casterlé et al. (1998) has recently proposed an adjusted version of Kohlberg's theory as valid for research in nursing ethics. However,

influenced by Gilligan's critique of Kohlberg the orientation in nursing research began to change and the validity of applying Kohlberg's theory to nursing is questioned by nursing scholars such as Ketefian (1988) and researchers such as Parker (1990).

As already mentioned, Gilligan challenged the validity of Kohlberg's theory of moral development and its generalisability to the moral thinking of women. This is highly relevant to nursing, as nursing remains a predominantly female profession. The Gilligan/Kohlberg debate had a significant effect on nursing research with the result that much research centred on some of the issues arising from the debate. Research was conducted, for example, to examine the applicability of the theoretical frameworks of Kohlberg or Gilligan. Other research investigated whether the ethical reasoning and decision-making of nurses was justice or care orientated, whether the two theoretical frameworks could be combined, and whether there were gender differences in the ethical reasoning and decision-making of men and women.

Corley and Selig (1994), for example, used the Nursing Dilemma Test to investigate the degree to which American critical care nurses use Kohlbergian-based principled thinking. The study reports that nurses, both men and women, show significantly more principled thinking (62%) than merely practical reactions to hypothetical ethical situations, and thereby appears to endorse the use of Kohlberg's theoretical framework. Sherblom et al. (1993), on the other hand, felt that Kohlberg's theory of moral development was inadequate and based their study of American female nurses on Gilligan's work. The study uses hypothetical dilemmas and interviews, and finds that nurses use both a justice-based approach, where they are concerned with fairness, patients' rights and autonomy, as well as a care-based approach where they are concerned for patients' needs, pain, emotional support, and relationships.

Other research has similar findings. Cooper (1991), for example, used semi-structured interviews to investigate American female critical care nurses, and finds they rely on both a principle-orientated ethic where they employ traditional moral principles such as respect for persons, patient autonomy, beneficence and fidelity, as well as the ethic of care. Cooper (1991) points out that the way in which the literature presents principle-based and care-based ethics as distinct frameworks does not always represent the moral reasoning of nurses, which goes beyond the rational use of principles to include "... a

complex, uncertain, and emotionally laden process of moral struggle.” These findings appear to be supported by Rickard et al. (1996) who used a structured questionnaire and hypothetical dilemmas to investigate the ethical decision-making of Australian nurses and doctors, and finds that nurses and doctors, both men and women, use both “partialist” caring-orientated and “impartialist” justice-orientated modes of reasoning.

Norberg and Uden (1995) have similar results in their study exploring the moral reasoning of Swedish nurses (both registered and enrolled) and physicians practising in geriatric and surgical care. Using interviews in which participants are asked to relate morally problematic care episodes and then using phenomenological hermeneutic analysis of the data they conclude that moral reasoning does not differ between men and women and that registered nurses and physicians alternate between emphasising care and justice. This finding is supported by Jecker and Self (1991:304) who, in critiquing professional stereotypes, argue that both medicine and nursing are caring professions and both men and women care for and about their patients. Additionally, Brabeck (1983) argues that justice and care should be seen as a whole and not two different models.

The research conducted by Norberg and Uden (1995) represents a recent trend whereby nursing research is concerned to use explorative methods to investigate the ethical reasoning and decision-making of nurses in practice, rather than measuring tools, questionnaires, and hypothetical moral dilemmas. Indications are that this approach is fruitful and will reveal greater insight and knowledge of the way in which nurses ethically reason and make decisions in clinical practice. Such research appears to be moving beyond the confines of the Kohlberg/Gilligan debate. Grundstein-Amado (1993), for example, interviewed Canadian nurses and doctors from a number of care settings in order to seek responses to both previous experience and a hypothetical case. She concludes that there are differences between the self reported behaviour of participants and their potential moral capacity and recommends further research in order to understand the subjective realities of individuals involved in the decision-making processes, their values and the meaning they ascribe to their choices. Additionally, Smith (1996) conducted a phenomenological study designed to examine the experience of American staff nurses as they engage in ethical decision-making. After analysing the interview data gained from the participants who practised in a variety of care contexts, Smith concludes that ethical decision-making is a dynamic process that staff nurses

encounter routinely although it is not always recognised. She also concludes that ethical decision-making consists of four major aspects: context, trigger, ethical decision-making and outcomes. This, she argues is very different from the traditional Kohlberg picture and represents a much more complex process than that suggested by the justice/care perspective. More recently, Holm (1997) has investigated the ethical reasoning of Danish nurses and doctors. Employing a grounded theory approach and using semi-structured interviews and case studies he identifies the notion of “protective responsibility” as important in his sample’s reasoning, and concludes that nurses and doctors use a mixture of moral theory including consequentialism, deontological ethics and virtue theory.

JUSTIFICATION FOR STUDY

Having completed a review of the theoretical and research literature, I believe there are several reasons justifying this study into the ethical reasoning and decision-making of nurses. First, in view of the fact that nurses have a personal and professional responsibility to ensure ethical practice in what is an increasingly complex practice environment, it is surprising to find that their ethical reasoning and decision-making has been under-researched. The practical relevance to nurses of much of the ethical theory found in the literature has been little explored, and much of the research that has taken place has been deductive in orientation and designed to test theory. There has been relatively little inductive research designed to investigate the ethical reasoning and decision-making of nurses in practice (Holly, 1993; Grundstein-Amado, 1993; Smith, 1996; Holm, 1997). Additionally, as the literature review indicates, much of the research that does exist is North American together with contributions from other parts of the world, particularly Scandinavia. There is virtually no empirical research on the subject reported in this country. Clearly a requirement for further empirical research has been demonstrated.

Secondly, it is important to the nursing profession and individual nurses that there is a greater understanding of their ethical reasoning and decision-making. From the point of view of the profession public trust and confidence is dependent on the provision of ethical care. To ensure ethical care it is necessary that the profession has a research based understanding of the way in which nurses ethically reason and make decisions together with the contextual, influencing and sometimes limiting factors. There is some research

to suggest that the ethical decision-making of nurses is limited by professional and institutional constraints (Sherblom, et al. 1993), by environmental barriers (Holly, 1993) and by the socialisation process involved in becoming a qualified nurse (Chaplin, 1993). On an individual level nurses are seen by the profession as being personally accountable for their professional practice (UKCC, 1992) and therefore have a responsibility to ensure the ethical nature of their practice. Yet, there is research to suggest that nurses have difficulty in identifying both the ethical nature of their practice (Gold, et al. 1995), and the ethical decisions that they face (Smith, 1996). Additionally, repeated exposure to moral conflicts may cause nurses moral distress (Wilkinson, 1987). Research into the ethical reasoning and decision-making of nurses will hopefully contribute to our knowledge in this area and assist both in terms of the ethical autonomy of the nurse and the provision of ethical nursing care.

Thirdly, the importance of the teaching of ethics in nurse education is self-evident and well documented (Calley, 1990; Gallagher and Boyd, 1991; Tadd, 1994). Formal ethics teaching enables students to ethically reason at higher levels (Felton and Parsons, 1987), but rhetoric and practice needs to be linked (Scott, 1996). It is essential that the teaching of ethics be guided, enriched and made more pertinent by the results of research into the ethical reasoning and decision-making of nurses in clinical practice.

In summary, this study is justified from the perspectives of the nursing profession, the individual nurse, and nurse education. The justification is underlined by the fact that there is, surprisingly, little reported research on a subject so centrally important to the provision of care. It is hoped that the knowledge and understanding gained from this study may be helpful in the continuing quest to provide high quality ethical care.

AIM, OBJECTIVES AND RESEARCH QUESTION

As a result of the literature review the aim, objectives and research question of this study may be formulated as follows:

Aim: to explore the ethical reasoning and decision-making of nurses in professional practice.

Objectives:

- To investigate the presence or absence of a theoretical framework, or theoretical frameworks, that might represent the ethical reasoning and decision-making of nurses
- To investigate the degree to which types of ethical reasoning found in traditional and alternative moral philosophies are evident in the ethical reasoning and decision-making of nurses
- To investigate the ethical experiences of nurses and the environmental and situational factors that might influence their ethical reasoning and decision-making
- Based on findings, to make recommendations relating to the teaching of health care ethics to student and post-graduate nurses, and the provision of a practice environment sympathetic to the ethical reasoning and decision-making of nurses

Research question: how do nurses ethically reason and make decisions in professional practice?

CHAPTER TWO

METHODOLOGY

The purpose of this chapter is to present the methodology used in this study. The chapter will begin with a discussion of the history and philosophy of ethnography. It will also address the setting, data collection, data analysis, writing up the study, reliability, validity and representivity, and ethical considerations.

THE HISTORY AND PHILOSOPHY OF ETHNOGRAPHY

As I have chosen ethnographic methods as a means of conducting this study it is necessary to begin this chapter with some discussion regarding the nature of ethnography. In doing so I will explore its definition and historical background, with reference to positivism and naturalism, and summarise why I have chosen ethnographic methods.

Ethnography – a definition and historical background

In general, ethnography refers to a method of social research that involves the empirical study of peoples' lives (Taylor, 2002). The researcher gathers data in the 'field' by participating, observing, questioning and collecting "... whatever data are available to throw light on the issues that are the focus of the research" (Hammersley and Atkinson, 1995:1). Data analysis involves interpreting the meanings and functions of human actions with little or no use of quantification or statistics (Atkinson and Hammersley, 1994:248). Ethnography may be seen as a research philosophy that requires total commitment or (which is my position) as a number of specific research methods that may be used when considered appropriate (Atkinson and Hammersley, 1994:248).

In discussing the history of ethnography, Vidich and Stanford (1998:46) emphasise that it is concerned with the “discovery of the other”. They refer to the Greek origin of the term ‘ethnos’, meaning a people, race or cultural group that when formulated into the term ‘ethnography’ refers to the “... science devoted to describing ways of life of humankind” (Vidich and Stanford, 1998:46). Modern ethnography has its origins in the nineteenth and twentieth century when social and cultural anthropologists employed ethnographic methods in collecting firsthand data to investigate the culture of different peoples (Atkinson and Hammersley, 1994:249). Nineteenth century studies of historical texts employing hermeneutic methods recognised that the cultural worlds of people who lived in different historical times could not be understood by applying current cultural norms, and should not be viewed as culturally backward (Atkinson and Hammersley, 1994:249). Subsequently ethnographic methods were used to study existing cultures that differed from that of the Western world, and eventually to study the various settings of our own social world.

The development of modern ethnography was greatly influenced by both the founders of modern anthropology and the Chicago school of sociology. Atkinson and Hammersley (1994:250) refer to the contribution of three anthropologists, Boas, Malinowski and Radcliffe-Brown, in advocating the firsthand collection of data to investigate ‘primitive’ cultures rather than inferring their history or judging them in terms of evolutionary level. Their prime motive was to reject speculation in favour of empirical investigation. The Chicago school of sociology of the 1920’s and 1930’s whose major figure was Robert Park was concerned with the discovery of social cultural laws and attempted to combine both scientific and hermeneutic views (Atkinson and Hammersley, 1994:251). In order to do so, the movement was influenced by pragmatist philosophy and the writings of William James, John Dewey and George Herbert Mead (Atkinson and Hammersley, 1994:251). Herbert Blumer is worthy of particular mention in that he critiqued the use of quantitative methods, proposed naturalistic research, and, influenced by George Herbert Mead amongst others, advanced the symbolic interactionist conception of human activity (Hammersley, 1989).

The anthropological and sociological origins of ethnography were to varying degrees influenced by the traditions of the so-called ‘natural sciences’ (Atkinson and

Hammersley, 1994:251), and also by naturalism, which developed in opposition to the 'natural sciences' (Hammersley and Atkinson, 1995:3). A feature of the history and development of ethnography has been the debate, which continues to this day, between these two philosophical positions, the 'natural sciences', often referred to as 'positivism', and naturalism (Hammersley and Atkinson, 1995:2-3).

Positivism

Positivism has been very pervasive (Lincoln and Guba, 1985:28) and yet today is often seen as little more than a term of abuse amongst social scientists (Hammersley and Atkinson, 1995:3). Positivist thinking was stimulated by the scientific developments of the seventeenth century and influenced by nineteenth century philosophers such as Auguste Comte in France, John Stuart Mill in England, Herbert Spencer in America and Ernst Mach in Germany (Hammersley, 1989).

So, what is positivism? Hammersley (1989:17) uses the term to refer to a combination of three ideas. The first, influenced by natural law theory, is the belief that the aim of studying the social world is to establish universal laws. As a result events can be explained in terms of laws that can be generally applied, and findings can be generalised. The second, is the restriction of knowledge to experience, the belief that we only have knowledge of phenomena via our senses. Any reference to extra-sensual phenomena may be dismissed as metaphysical speculation. This concentration on directly observable phenomena leads to an emphasis on standardising data collection methods and the belief that measurements are stable between observers, the creation of what Hammersley and Atkinson (1995:4) call a "neutral observation language". The third idea, is the belief that science represents the most valid form of human knowledge and that the methods of physical science may be applied to the study of the social world. The central model of such methods is that of the experiment where quantitative measurements of variables are contrasted in order to establish relationships.

Naturalism

Naturalist inquiry developed as a reaction to positivism (Denzin, 1989:69) and holds that the social world should be studied in its 'natural' state, undisturbed by the researcher (Hammersley and Atkinson, 1995:6). Referring to the critique of positivism by Habermas, Lincoln and Guba (1985:29) note five features of positivism objected to by naturalism: objectivity, hypothetical-deductive theory, external law-like relations, exact and formal language, and the separation of facts and meaning. Lincoln and Guba (1985:37) provide a good characterisation of the contrasting positions of naturalism and positivism. They point out that with regard to the nature of reality, naturalistic reality is multiple, constructed and holistic, whereas positivism holds that reality is single, tangible and fragmentable. Regarding the relationship between the knower and the known, naturalism holds that they are interactive and inseparable, as opposed to the positivist view that they are independent and dualistic. Regarding the possibility of generalisation, naturalism holds that only time and context-bound working hypotheses are possible, whereas positivism holds that generalisations can be time and context-free. With regard to the possibility of causal linkages, according to naturalism as all things are in a state of change it is impossible to distinguish causes from effects, whereas positivism holds that there are real causes linked with their effects. Finally, Lincoln and Guba (1985:37) point out that with respect to the role of values, naturalist inquiry is value-bound, as opposed to the positivist idea that the inquiry is value-free.

According to Lincoln and Guba (1985:39-43) the naturalistic position has a number of implications for research. They emphasise the importance of the natural setting, the use of human rather than mechanical instruments for data collection, and the utilisation of tacit (intuitive) knowledge as well as propositional knowledge, that is, knowledge expressed in language form. They also stress the importance of qualitative methods, purposive sampling, inductive data analysis, grounded theory, an emergent design, and outcomes that are negotiated with respondents. They also emphasise the importance of case study reporting mode, idiographic (in terms of the particulars of the case) rather than nomothetical (in terms of law-like generalisations) interpretations, and the need to be tentative or hesitant about suggesting broad application of findings. Finally they suggest the need for focus-determined boundaries

that emerge as the research progresses, and special criteria for trustworthiness rather than conventional criteria of internal and external validity, reliability and objectivity.

Naturalism, indeed ethnography in general, is itself criticised. Hammersley and Atkinson (1995:14) appear to challenge the view of Lincoln and Guba (1985:29), claiming that naturalism can share with positivism a commitment to value neutrality and objectivity and the production of findings that are independent of the values of the researcher. Naturalism and ethnography are challenged in this way from a number of positions. Feminists, for example, argue that the findings of much social research reflect the masculine assumption of the researchers, while Marxists argue that they reflect the dominant bourgeois class ideology, and similar arguments are to be found amongst black sociologists (Atkinson and Hammersley, 1994:252). Other critiques of the purported realism of naturalism come from post-structuralism and post-modernist thinkers. Hammersley and Atkinson (1995:14) refer to Jacques Derrida's ideas relating to the deconstruction of language, which suggest that ethnographic accounts are a result of rhetorical strategies employed by the researcher, rather than a realistic interpretation of phenomena. Hammersley and Atkinson (1995:14) also refer to Michel Foucault's ideas on power, which challenge the notion of independent realism by suggesting that surveillance and control is one of the main functions of modern society, and social research inevitably embodies this. According to this perspective, therefore, the findings of any social research must be seen in this light rather than as an account of an independent reality.

A final criticism, sometimes made, of ethnography involves the political valuing of research and a concern that ethnography concentrates on finding out about the world rather than changing it. All research has political consequences and researchers should take responsibility for the effects of their findings, whether this takes the form, for example, of influencing national policy or professional practice. There is also the argument that research should be emancipatory whereby its goal is social change in order to achieve greater freedom, equality and justice (Hammersley and Atkinson, 1995:15).

Why ethnography?

Taking into account the critical points summarised in the above discussion, I have chosen to use ethnographic methods in this study for several reasons. Essentially, the underlying assumptions of ethnography, with some reservations, are acceptable to me. Of particular relevance is the recognition of the importance of culture and the belief that the social world should be studied in its natural state, the importance of empirical study, and the appropriateness of qualitative methods. The underlying assumptions of ethnography may be summarised as follows: that a person's behaviour is inextricably linked with the meaning that the situation has for him or her, that a person's understanding and hence behaviour changes as interaction takes place with others, that within a situation there will normally be different perspectives, that a person's behaviour and beliefs can only be fully understood in the light of broader aspects of organisation or culture, and that the group or culture must be studied "as it is" (Hilton, 1987 cited by Mackenzie, 1994). As I believe that the ethical reasoning and decision-making of nurses must be viewed within the environment and context in which they take place, ethnographic methods are particularly appropriate and useful.

THE SETTING

For reasons of confidentiality the setting for this study cannot be named or identified and details must be kept to a minimum. Suffice to say that the study took place on a cardio-thoracic surgical ward in a busy cardiac services unit in a large hospital in the United Kingdom. The Lead Nurse responsible for the unit granted access and the local health authority's ethics committee gave ethical approval.

Certain factors were taken into considerations when choosing the setting. Theoretical interest, potential access, or already being involved in it and deciding to study it, are reasons for selecting a particular setting (Adler and Adler, 1994:380). In a sense all three reasons were relevant. Of primary importance though, was whether it was a setting where the topic of the study could be investigated (Hammersley and Atkinson, 1995:37). My knowledge of the setting as a busy cardio-thoracic surgical ward suggested that it would give rich data on the ethical reasoning and decision-making of nurses in cardio-thoracic care. Additionally, as a lecturer who practised in cardio-

thoracic care, it was a setting and practice area that I had a particular interest in investigating. Practical considerations such as likely access and travel to and from the setting were also taken into account.

Choosing to investigate just one setting is not unusual in ethnographic research (Hammersley and Atkinson, 1995:39). It facilitated a more in-depth study of the particular setting I was interested in and involved an economic use of time. The fact that I would be less able to generalise findings was not a major consideration. Hammersley and Atkinson (1995:42) point out that "... sometimes, ethnographic research is concerned with a case that has intrinsic interest, so that generalization is not the primary concern." I saw the investigation as an opportunity to study the ethical reasoning and decision-making of nurses within that specific environment and that, true to ethnographic research, I would be able to make tentative conclusions that might be applicable to other areas of nursing practice. I hoped that this would stimulate and lead to further research.

DATA COLLECTION

The primary method of data collection was via interviews with nurses. Observational methods, both participant and non-participant, and the taking of field-notes were also used. As the study progressed, interviews became the primary source of data and much less emphasis was given to participant and non-participant data gathering. In ethnographic studies it is acceptable to use interviews alone or in combination with other methods of data collection (Hammersley and Atkinson, 1995:132).

Interviews

The use of semi-structured interviews

Eighteen nurses took part in semi-structured interviews. The interview is the most important method of data collection for ethnographers (Fetterman, 1998:37). There are a number of ways in which qualitative interviews are defined. Commonly they are defined according to the degree to which they are structured. Interviews are, for example, identified as being "structured", "semi-structured" or "unstructured"

(Fontana and Frey, 2000:645-6) or as being “schedule standardized”, “non-scheduled standardized” or “non-standardized” (Denzin, 1989:104-106) or as being “standardized open-ended”, “interview guide” or “informal conversational” (Patton, 1987:116). The ‘semi-structured’, ‘non-scheduled standardised’, or ‘interview guide interview’ are terms that best describe the form of interview I conducted. I did not have a defined schedule of questions. Interviews were not standardised in this way. They were focused, in that I had formulated a list of the general areas I wished to cover (see **appendix 3**). The sequence and wording of questions was decided upon as each interview progressed. There were advantages in employing this method. It allowed me to sequence questions in response to the interviewee’s readiness and willingness to discuss particular topics (Denzin, 1989:106). Additionally, in constructing questions I employed words and terms used by the interviewee, a practice that recognises individuals have unique ways of defining their world, and helps the interviewer to meaningfully understand that world (Denzin, 1989:105).

Rapport

Rapport between interviewer and interviewee is an important feature of the ethnographic interview (Hammersley and Atkinson, 1995:141). In fact, Spradley (1979:58-9) sees the ethnographic interview as a “speech event” that shares many features with a friendly conversation, and points out that during the interview it is useful to shift back to “friendly conversation” as a useful way of maintaining rapport. In order to develop rapport it is useful for the researcher to have already built up a good relationship and positive reputation within the setting. Measor (1985) emphasises the importance of building a relationship and outlines various strategies for doing so, such as considering one’s appearance, and using shared interests and biographical experiences. I found that my personal and professional biography was important and I was particularly fortunate in this respect. I was known to many of the nurses, and having a nursing background and professional interest in the specific area meant I could relate to them and their professional experiences. This is illustrated well in the reflective notes I made following the interview with Rebecca:

This was a very interesting and enjoyable interview. The interview in my opinion flowed well and there was a sharing of experiences, thoughts,

jokes and laughter. The fact that we had known each other professionally for a long time probably contributed to this. (26th May 1998)

While the interviews shared many characteristics of “the rapport interview” they also shared some of the features of “the depth interview” (Massarik, 1981:202-3). I was involved in exploring, more deeply than I might have done in a rapport interview. I was concerned with the interviewee as a person and interested in their views and experiences relating to the topic of the study. Additionally, there was a sense that the interviewee reciprocated my interest, valued my motives and sought to help and respond to the appropriate depth. Interviewees would ask questions, seek clarification, and generally took part in the process of seeking understanding (Massarik, 1981:203).

Sampling

With regard to selecting interviewees, I had little difficulty in finding nurses willing to be interviewed. Almost without exception they were enthusiastic to take part, to share their experiences and to be listened to. I did strive to achieve a representative sample, though this is not a necessary requirement in ethnographic studies (Hammersley and Atkinson, 1995:137). In fact, virtually all nurses in the clinical area were interviewed. All grades of nurse took part, ranging from recently qualified ‘D’ grades to ‘G’ grade sister/charge nurses. Interviewees represented a wide range of experience and clinical expertise. For reasons of confidentiality, I do not wish to give a breakdown in terms of gender, except to say that interviewees were predominantly, but not exclusively, female.

The interview venue

The choice of interview venue was important and was generally agreed upon after negotiation with the interviewee. Most interviews were conducted in the natural setting of the ward. It is usual for ethnographic interviews to take place where the interviewee usually operates (Hammersley and Atkinson, 1995:140). There were a number of advantages to this. Being in familiar surroundings helped the interviewee feel more relaxed (Hammersley and Atkinson, 1995:150). It was also convenient and made it easy to fit the interview into the daily schedule of interviewees. Interviews

usually took place at the end or during a shift, though this practice had disadvantages that affected the interview. When the interview took place following a shift the interviewee was often tired, and when it took place during a shift, time was limited, there was the need to return to work and there were interruptions. In choosing the interview venue it is important to take into account likely distractions and interruptions (Hammersley and Atkinson, 1995:148). My concern about interruptions and the appropriateness of venues used was illustrated in some of my reflective notes made following interviews. After the interview with Winny I wrote:

The use of the disused four-bedded bay had its problems. Though it was secluded and private and we were not disturbed it was rather spacious and perhaps made it difficult to conduct an intimate interview. The effect may be that Winny was not as forthcoming as she might otherwise have been. (20th February 1998)

A similar venue was used for the interview with Sally. Different problems were highlighted in my reflective notes:

The interview took place in a disused four-bedded bay area on the HDU, which is used now as a general office and administration area. I have now done a few interviews using this venue. One drawback is that it can be noisy. The interview was disrupted by noise from traffic outside and we were interrupted... by staff coming into the area in order to get various things – this was an interview where Sally recited some very painful experiences. (8th May 1998)

Another venue commonly used was the sister's office on the ward. Noise and disruptions were sometimes problematic. Following the interview with Zoe I wrote:

The venue was convenient in terms of location but had disadvantages. It was somewhat noisy as building work was taking place. Additionally, we were subject to interruptions. During the interview the telephone rang and this clearly disrupted the interview as Zoe lost her train of thought. We were also interrupted by one of the sisters coming into the office not realising that the interview was taking place. (15th December 1997)

Not all interviews took place in the clinical environment. Xaria agreed to be interviewed and suggested that it take place at her home. Following the interview I wrote the following reflective comments:

As this was the first interview conducted outside of the clinical context I reflected on the influence of the venue on the outcome of the interview. In this case the venue gave the interview the character of being relaxed and friendly. I got the impression that Xaria really did feel comfortable and at ease during the interview. (19th December 1997)

The interview process

There were several important considerations regarding the interview process, such as the character of the interview, how it started and concluded, and the type of questioning I used. As already stated I maintained a flexible approach. I entered the interview with a list of areas I wished to cover rather than a list of questions. The sequence of questioning evolved as the interview developed. My general aim was to explore the world of the interviewee and in particular their ethical reasoning and decision-making. I tried to ensure that the interview was a friendly affair where interviewees felt relaxed and comfortable in sharing their thoughts and experiences. Usually the interview did take the form of a conversation but, as Hammersley and Atkinson (1995:152) point out, it was never simply a conversation, as I had a research agenda and needed to control the proceedings.

The initial stages

I felt the initial stages of each interview were important and set the tone. Before starting each interview I explained its nature and purpose to interviewees in order to seek their consent. An information leaflet (**appendix 5**) was also given to interviewees for this purpose. Indeed, “ethnographic explanation” whereby the researcher continually offers explanations to the interviewee, is an important process in interviewing (Spradley, 1979:59). After they had given consent, I generally commenced the interview by thanking the interviewee for taking part, explaining what I was doing and then asking simple, friendly “grand tour” (Lincoln and Guba, 1985:270) questions such as, “What has been your clinical experience since qualifying as a nurse?” This had a number of advantages. It helped the interviewee feel relaxed, it initiated the interview process, it helped the interviewee get used to answering questions, and it gave me useful information.

Often the interviewee would very quickly start to give important cultural and environmental information, as this transcript of the beginning of the interview with Lucy illustrates (some of the details have been changed in order to preserve confidentiality):

Cliff: I'm going to ask you a few questions. It's like we are going to have a chat really about working here and some of the difficulties you might face and some of the issues that come up. If I start writing, don't worry about that, it's just that as I'm thinking, I must take a note about that so I can ask you a question later. So don't worry about that. And really I think I'll start simply by asking you questions about how long you've been qualified. When did you qualify?

Lucy: I qualified October, I think the twentieth. I started here in October. So I have been qualified for a year and four or five months, a year and half, so.

Cliff: So, this was your first post after you qualified?

Lucy: Yea, Yea, I know.

Cliff: So, is it an easy place to start, do you think?

Lucy: No, it's not. The easiest place to start I think will always be where you did your training. Because you are into the system there. You know what the paperwork are like; you know what the people working on the wards are like, etc. So I think, definitely not the easiest thing to do. And London as well is always very short of staff so you always get thrown into the placement or the work area more than you do in the other place. You don't get the same support I think. It's definitely not the easiest thing to do.

Cliff: Because you didn't train here in London?

Lucy: I trained in Northamptonshire. Yea, not in London at all. So, I decided to, instead of suddenly becoming the newly qualified student on the ward to take the big step and to go out and do something different. I've enjoyed it, yea.

Cliff: As a newly qualified person then, do you feel you were given the support you required?

Lucy: No I wasn't. Definitely not. The only reason I accepted this position was because I was promised six months preceptorship. And included in that six months preceptorship was four weeks supernumerary. I had two days supernumerary when I went up to see cardiac surgery and down to angiogram to see pacemakers being placed in etc. Otherwise I didn't have any supernumerary time at all. They didn't even give me the

chance to get into the ward. I was basically just thrown on patients. My mentor left the ward, so suddenly I was left without a mentor, no one went through any objectives with me. The only reason I took this position was because I was going to have this preceptorship program which seemed excellent at the time. I was provided with this preceptorship package before I even went for the interview so I could have a look at it and really decide in my mind if I want to go for it or not. And everybody was very positive in the interview. It came and I was just chucked in it with no support at all.

Cliff: Why was that then?

Lucy: Shortage of staff. Most of the nurses that had been here recently just had left to other wards. And suddenly they were left with, I think we had four or five newly qualified 'D' grades on the ward at the same time. And suddenly we were all running the ward without getting any support. A bit of a nightmare, yea...

During interviews I was conscious of a certain tension. On the one hand I wanted to minimise my influence on the interviewee so that the discussion flowed in the direction the interviewee wanted it to go, as this might lead to new and unexpected areas of interest. On the other hand, as Spradley (1979:59) points out, ethnographic interviews have an "explicit purpose" and I needed, in a non-authoritarian way, to take control and lead the discussion to areas of relevant interest.

Questioning

It was important to consider the questions used in interviews. The content of questions was designed to elicit from the interviewee information concerning their ethical reasoning and decision-making and the environment and culture in which this took place. In each interview I normally used different types of questions. This is usual in ethnographic interviews (Hammersley and Atkinson, 1995:152-5). Questions were non-directive and open-ended when I was generally exploring issues, or directed and leading when I wanted to examine something the interviewee had said, or to explore a particular area or topic. Spradley (1979:60) usefully identifies different types of ethnographic questions that he describes as being "descriptive", "structural" and "contrast" questions. To a varying extent I used all three types. Descriptive questions are designed to elicit basic information and to collect an ongoing sample of the interviewee's language. Here I would ask a question such as, "Could you describe the



ethical difficulties you experience on the ward?” Structural questions are designed to discover how the interviewee has organised his or her knowledge. An example of a structural question I used was, “When faced with an ethical choice what are your priorities?” Finally, contrast questions are designed to explore the meanings attached to different terms by the interviewee. For example, when exploring what was meant by the term ‘ethical dilemma’, I would ask a question such as, “What for you is the difference between an ethical dilemma and a difficult choice?”

Terminating the interview

Deciding when to terminate an interview was another area requiring some thought. On most occasions the interview came to a natural end. The interviewee may have had to return to work, became tired, or indicated that they had nothing more to add. This is illustrated in my reflective notes written following the interview with Quincy:

It is interesting how the interview seemed to come to a natural end. In interviews usually there are various cues from the interviewee that they have had enough. In this case it was the fact that there was, it appeared to me, a gradual decrease in the interviewee’s development and explanation of points towards the end of the interview. (29th May 1998)

To ensure that the interview was completed I felt it was important to ask the interviewee if he or she had anything else to add. I also felt it was important to demonstrate that I valued the interviewee’s contribution by thanking them for it. Occasionally the interviewee indicated that they had found the interview to be an interesting and valuable reflective process. For example, when the interview with Winny was coming to a conclusion, I asked her if she had anything more she would like to add. She replied:

Nothing now. This whole conversation has actually been very interesting because it has actually allowed me to reflect on many things that I have done or situations that I have dealt with which have been difficult at times. I haven’t ever maybe sat down and thought, “O gosh, I’ve got to deal with this number of difficult decisions.” So it has certainly allowed me to reflect on that. (W791)

Audio-tape recording

All interviews were audio-tape recorded. This had the obvious advantage that I had a verbatim record of the interview that I transcribed and was able to review time and again (Lincoln and Guba, 1985:272). All nurses agreed to be audio-tape recorded and, as Burgess (1982:118) indicates, if good rapport exists with the interviewer the tape recorder can be accepted without hesitation by the interviewee. There were however some disadvantages. The use of a tape recorder can act as a barrier, and threaten and inhibit (Spradley, 1979:74), and may constrain open and candid responses (Lincoln and Guba, 1985:272). There were hidden problems, as illustrated by the reflective notes I made following the interview with Winny:

Winny is an extremely experienced sister who I thought would have many examples of difficult ethical situations... I got the impression that the interviewee was somewhat restrained. At the end of the interview I turned off the tape recorder and she immediately relaxed and said that she had felt tense and that she did not like to be recorded because she does not like the sound of her own voice. (20th February 1998)

Data collection continued for a period of about fifteen months from December 1997 until March 1999. During this period I was involved in a constant process of collecting data and analysing it. The relationship between data collection and analysis in ethnography is a close one. Hammersley and Atkinson (1995:205) point out that the researcher is required to have a commitment to a “dialectical interaction” between the two. I was involved in a cyclic process of data collection – analysis – data collection – analysis. I formulated my initial findings following the analysis of the first round of interviews. Early assumptions and ideas resulting from initial analysis were followed up, compared and checked as further data was gathered. I undertook a second round of interviews and analysis. I continued data collection until I felt nothing new was emerging, that findings were repeating themselves, and it appeared that I had reached the stage of “theoretical saturation” (Strauss and Corbin, 1990:188).

Observational methods

Observational methods were initially useful because they took place in the natural setting under study and gave an insight into that world and its complexities. The

advantages of fieldwork and observation are well documented. According to Grills (1998:4), by "... going where the action is" the researcher seeks "... familiarity with the 'world of the other' through getting close to the dilemmas, frustrations, routines, relationships, and risks that are a part of everyday life." Adler and Adler (1994:378) similarly point out, qualitative observation "... follows the natural stream of everyday life" and has the advantage of "... drawing the observer into the phenomenological complexity of the world, where connections, correlations, and causes can be witnessed as and how they unfold." Indeed, Adler and Adler (1994:386) refer to Dilthey (1961) who proposes that we seek 'Verstehen' (understanding) of others by empathising with them and the capacity to do this is enhanced by the process of observation whereby a deeper existential understanding of the world as experienced by others is gained.

The use of observational methods, combined with interviews, was useful because I could improve the validity of the data gathered. Interview data could be cross-checked with observational data and vice-versa with, as Adler and Adler (1994:382) point out, the hopeful benefits that the data has greater breadth and depth, and enhanced consistency and validity.

As the study progressed the importance of gathering observational data diminished. There were a number of reasons for this. To some extent my observations did not follow the normal pattern from "descriptive" to more "focused" and "selective" (Adler and Adler, 1994:381), as the focus of the study (ethical reasoning and decision-making of nurses) was known at the start and observations were directed towards this from the outset. Initial observations and notes were useful because they related to important environmental and cultural features. However, as data collection became more focussed on the topic being investigated the formal interview emerged as the most effective method of collecting this data. Additionally, there were difficulties associated with my participant and non-participant observations. I became aware of the potential problem of researcher bias. In the process of looking for ethical situations I felt my observations may have been influenced by my preconceptions, and that these might differ from those identified by nurses. In addition, while I could verify some of the general ethical issues mentioned by nurses, such as shortage of

nursing staff, I was seldom present to witness ethical events raised by nurses in interviews.

Overall, my observations were useful in familiarising me of the nurses' 'world', and in informing me of factual information relating to matters of culture, organisation and management of cardio-thoracic surgical care. However, in presenting my findings, while I have taken my observations into account, I have not referred to them specifically, apart from a few references to my reflective diary in this chapter. Because of this, and the fact that interviews emerged as the richest source of data, my data analysis focuses on that gathered from interviews.

DATA ANALYSIS

In analysing the interview data I have employed two methods. I began by using a "traditional approach" (Riessman, 1993:3) to data analysis, that of coding. This was followed by a second, alternative and complementary analysis, that of narrative analysis using poetic representation. I will begin by first outlining the way in which I analysed the data using coding methods.

Coding

At the beginning of data analysis a number of questions presented themselves. Where do I start? What was I looking for? How do I make sense of the data? How do I organise it and make it manageable? And so on. One of the first tasks was to establish a "focus" (Dey, 1993:63-4). This was reasonably straightforward. The study had been conceived with a purpose in mind, to investigate the ethical reasoning and decision-making of nurses. This was its central focus, its purpose, so to speak. However, Dey (1993:64) warns that in establishing a focus it is important to have an open mind and not to ignore other options. For me this soon became apparent as it emerged that in exploring the ethical reasoning and decision-making of nurses I also needed to examine related issues, such as environmental and cultural factors associated with management structure, power and resource issues.

Coding – a definition

Having gathered the data, my next step was to make sense of it, to organise it and make it manageable. This involved the process of coding. Codes are, according to Miles and Huberman (1994:65), efficient “data-labelling and data-retrieval devices”. Additionally, coding may be seen in terms of data “simplification or reduction” (Coffey and Atkinson, 1996:28) and is therefore a means by which data is made manageable. But coding is more than this. Coffey and Atkinson (1996:30) point out that coding is usually a mixture of reduction and complication. While the data is broken up to form simpler general categories, it is also reconstructed in order to form new questions and levels of understanding.

Open coding – becoming familiar with the data

The first step in analysing my data was the process of reading and becoming familiar with it (Hammersley and Atkinson, 1995:210). Interview transcripts were read and re-read repeatedly. This process of familiarisation with the interview data had of course began much earlier. In fact, my data collection and analysis were closely related. As I have already mentioned this is a feature of ethnographic research. My data analysis began as I collected my data. During interviews, as interviewees related their thoughts and experiences, I was continuously involved in exploring and analysing what they said. When conducting interviews I made mental and literal notes. Additionally, much time was spent transcribing taped interviews and noting initial impressions and thoughts. Over a period of time I built up a close familiarity with the data. My aim during this initial process of analysis was to closely examine the data and to break it down into distinct parts that I could name and categorise, a process identified by Strauss and Corbin (1990:62) as open coding. Each interview transcription was analysed in this way (see **appendix 7** for an illustrative example). As each interview transcript was analysed I formulated categorised composites (see **appendix 8**). Initially, I conducted and analysed ten interviews. This was followed by a second round of data collection in which I conducted and analysed a further eight interviews.

Eliciting meanings and understandings

The process of breaking the data down into distinct parts in order to make sense of it and to elicit meanings and understandings, has a number of descriptions in the research literature. Hammersley and Atkinson (1995:209) refer to “generating concepts”, Strauss and Corbin (1990:62-3) to “conceptualizing”, and Lincoln and Guba (1985:203) to “unitizing”. All have a similar meaning. For example, “unitizing” involves the identification of information bearing units that are “... single pieces of information that stand by themselves, that is, that are interpretable in the absence of any additional information” (Lincoln and Guba, 1985:203). Hammersley and Atkinson (1995:210) usefully identify what one should be looking for at this stage. This includes: any interesting patterns, anything that stands out as surprising or puzzling, how the data relates to one’s expectations based on common-sense knowledge, official accounts, or previous theory, and finally, whether there are inconsistencies or contradictions among the views of different groups or individuals, or between people’s expressed beliefs or attitudes and their actions.

At this stage in the analysis I was struck by a number of observations, for example, a pattern appeared to be emerging where many of the ethical incidents faced by nurses were caused by the decisions of others (usually doctors) in a health care organisation which was structured hierarchically. Additionally, I expected there to be evidence in the data that nurses were exposed to difficult ethical situations, but the degree and extent to which this took place was surprising. All nurses were able to relate incidents they had been involved in or ethical issues that concerned them. It was also notable that the ethical reasoning and decision-making of nurses was complex and involved the use of elements from both dominant and alternative theoretical frameworks.

Categorising and the naming of categories

The process whereby I organised concepts or related pieces of data into groups is called “categorizing” by Strauss and Corbin (1990:65). Initially I formulated somewhat broad categories and naming them required careful consideration. According to Strauss and Corbin (1990:65) the name “... should be more abstract than

that given to the concepts grouped under it.” Furthermore, Strauss and Corbin (1990:67-8) stress that the “... important thing is to name a category, so that you can remember it, think about it, and most of all begin to develop it analytically.” Bearing these points in mind the following six categories were formed: the individual nurse, ethical sensitivity and practice, nursing – the profession, inter-professional relationships, environmental factors, and the patient, family and friends. It was clear from a very early stage that these categories were provisional and were likely to need changing as the analysis progressed. This was illustrated by the fact that the two categories “individual nurse” and “ethical sensitivity and practice” were very closely related and shared some of the concepts/units.

Axial coding – making connections between categories and sub-categories

As the analysis progressed open coding was gradually used interchangeably with axial coding. Axial coding describes the process whereby the fragmented text, resulting from open coding, was put back together again in new ways by making connections between a category and its sub-categories (Strauss and Corbin, 1990:97). In axial coding, according to Strauss and Corbin (1990:97), the focus of the researcher “... is on specifying a category (*phenomenon*) in terms of the conditions that give rise to it; the *context* (its specific set of properties) in which it is embedded; the action/interactional *strategies* by which it is handled, managed, carried out; and the *consequences* of those strategies. These specifying features of a category give it precision, thus we refer to them as *subcategories*.” The use of axial coding facilitated the formation of the dimensional profiles of categories and sub-categories. This was an important part of the analytical procedure, as its purpose was to establish the relationship between categories and subcategories (Strauss and Corbin, 1990:69-70). I attempted to differentiate categories and sub-categories by continually comparing, analysing and moving pieces of data between them, a process described by Glaser and Strauss (1967) as the “constant comparative method”. I found myself moving quite a lot of data between different categories and sub-categories. As a result categories and their sub-categories gradually became more defined and new categories and sub-categories emerged (Hammersley and Atkinson, 1995:213). Though, it must be stressed that the resulting categories remain highly interrelated. Four categories emerged from the analysis: ‘The Nurse’, ‘Environmental Factors’, ‘Inter and Intra

Professional Relations’, and ‘Nursing and the Patient’ (see **appendix 10** for a summary of categories, sub-categories and their dimensional profiles).

Selective coding – identifying the core category

Following the formation of categories, subcategories and their dimensional profiles, there then followed, via the process of selective coding, the identification of the core category (Strauss and Corbin, 1990:116). According to Strauss and Corbin (1990:116) the core category is then systematically related to other categories, their relationships are validated and during this process other categories are refined. Determining the core category was difficult and the process of doing so not entirely satisfactory. The category entitled ‘The Nurse’ emerged from the analysis as the core category. It did so on the basis that it was the category most central in the relationships between all the categories. Quite simply, other categories revolved around it and in analysing the data it was the category I went into and out of most (see **appendix 9** for a visual presentation of the core category and how it relates to other categories). This was not to say that I considered it the most important category, but simply that it appeared central to the study. Additionally, it is important to stress the dynamic inter-relatedness of the categories, the fact that they were not tablets in stone and continued to evolve even as the study was in the stage of being written up.

Problems with coding

There were problems in using coding methods to analyse the data. Establishing clearly defined categories and sub-categories remained difficult. A single piece of data would often sit well in more than one category and it remained difficult to draw a clear line of demarcation between categories. The theoretical boundary between categories often remained blurred. Additionally, as Hammersley and Atkinson (1995:213) point out, the development of analytical ideas rarely took the purely inductive form implied by Glaser and Strauss (1967). My own expectations, knowledge, values and ideas were all influential. While this may have been useful, in that it allowed me to pick out surprising, interesting, and important features, it was also potentially problematic. Dey (1993:222-3) indicates two potential pitfalls, first, the potential for bias where “... we tend to make more of the evidence that confirms

our beliefs, and pay less attention to any evidence that contradicts them.” Secondly, the possibility of being “... seduced by the lure of providing plausible accounts we may ourselves produce fictions which conveniently ignore the more awkward and less easily accommodated facts in our data” (Dey, 1993:222-3). I became aware of this danger during the interview process as the following extract from my reflective notes, written after I had transcribed the interview with Winny, indicates:

There appears to be a lot more in the interview than I initially imagined. I have to be very careful, as I’m sure I have a preconceived view of what I should expect and what is “ethical” and what is not. I have tended to concentrate on ethical incidents and have overlooked the whole area of ethical behaviour. That is, the question of, “What is the right thing to do?” Almost, what is virtuous conduct? Clearly this is part of ethical decision-making as it involves the whole process of deciding how to practice. (20th February 1998)

Reflexivity

Reflexivity is an important tool in dealing with the problem of bias. It involves appreciating the biography of the researcher and the nature of the relationship between the researcher, the study and those involved in it. Reflexivity implies that, as the researcher, my orientation will be influenced by my socio-historical position, my values and interests. This research cannot be isolated from its social context, my particular biography and personal characteristics, and social processes, all of which inevitably affect findings (Hammersley and Atkinson, 1995:16). Guba and Lincoln (1994:107) are critical of the so called “received view” of science which views the researcher as standing behind a one-way mirror viewing and recording objectively and having no influence on or being influenced by the phenomena being studied. They suggest that a more plausible description of the enquiry process is that findings are created through the interaction between the researcher and phenomena. In this study, it is the interaction between myself as researcher and the nurses being studied. In short, as researcher, I influence and am influenced by the world being studied and record my interpretation of that world. This constructivist view is articulated well by Hammersley and Atkinson (1995:239) who point out that “... it is vital to recognize that ethnographers construct the accounts of the social world to be found in ethnographic texts, rather than those accounts simply mirroring reality. And those

accounts are constructed on the basis of particular purposes and presuppositions. Equally, one must recognise the significance of how those texts are read...[by] others.” The importance of reflexivity to the constructivist view of research is such that some question whether the inclusion of the researcher makes all research autobiographical (Steier, 1991:2).

Developing theoretical sensitivity

Being reflexive is important in developing theoretical sensitivity where, according to Strauss and Corbin (1990:76), “... we have to challenge our assumptions, delve beneath our experience, and look beyond the literature if we are to uncover phenomena and arrive at new theoretical formulations.” In this study I was well known in the research setting and in some respects was taking part in “insider” research. It was important to consider my biography, including my personal philosophy and values, knowledge and previous experience, as well as the relationship with the topic being investigated and the people involved. Such factors inevitably influenced choices I made relating to the research process, the gathering of research data, and the analysis of the data gathered.

Advantages and disadvantages of coding

Having completed my coded analysis resulting in the formation of categories, subcategories and their respective dimensional profiles, I was aware of some of the advantages and disadvantages of using a ‘traditional approach’ to qualitative analysis. While coding offered a recognised and respected systematic method of making sense of what at first appeared a daunting amount of data it has disadvantages. As Coffey and Atkinson (1996:52) point out, coding is not the final word on qualitative data analysis. While the method of coding I used helped formulate valuable conclusions I was aware that there was a price being paid. I felt uncomfortable with the process of fragmenting interview texts in order to form categories and sub-categories. A somewhat positivist process which fragmented reality and appeared to be at odds with the narrative nature of some of the interview dialogue. Parts of my interview texts read like a story and I was fearful that certain features were being lost, particularly its coherence and sequence. Riessman (1993:3) explains this process well and points out

that “traditional approaches” often “fracture” texts “... by taking bits and pieces, snippets of a response edited out of context. They eliminate the sequential and structural features that characterize narrative accounts.” Additionally, the fragmentation of a number of texts to form collective categories and sub-categories inevitable meant that the uniqueness of the individual dialogue was destroyed. As a consequence I was concerned that my analysis may be overlooking important aspects and may, in some ways, be incomplete. I therefore decided to complement the coded analysis with a narrative analysis approach to selected sections of my interview transcripts.

Narrative analysis

The first stage in this process was to identify and select from my interview transcripts sections of narrative for analysis. Clearly, in order to do this it was necessary to have an idea of what the term ‘narrative’ meant. There is much discussion in the literature concerning the definition of the term. Riessman (1993) points out that some definitions may be so broad as to include almost anything while at the same time other definitions are very prescriptive. Riessman (1993:17) surveys the literature and indicates that “narratives” may have some or all of a number of features. Narratives tend to have clear beginnings and endings and are stories about a specific past event (Labov 1972). The beginning and ending of a specific piece of narrative may be identified, according to Jefferson (1979), by entrance or exit talk. Narratives tend to follow a chronological sequence (Labov and Waletzky, 1967) and according to Young (1987) are consequentially sequential, that is, one event causes another. Michaels (1981) suggests that narratives may also be thematically sequential. In other words, theme rather than time unite them.

To identify narrative structures, most investigators, according to Riessman (1993:18), cite Labov (1972, 1982) and Labov and Waletzky (1967) who argue that a “fully formed” narrative has six common elements. According to Riessman (1993:18) these elements are, “... an abstract (summary of the substance of the narrative), orientation (time, place, situation, participants), complicating action (sequence of events), evaluation (significance and meaning of the action, attitude of the narrator), resolution (what finally happened) and a coda (returns the perspective to the present).”

Selecting sections of narrative

I reviewed my interview transcripts, and taking into account the different definitions of narrative, selected significant sections that took on a narrative form. Commonly, they appeared as large sections of text where the informant told a story about an incident or discussed a particular theme or issue. On occasions there were indicators as to when the narrative began or concluded.

Paradoxically, in selecting examples of narrative, I had to some extent fragmented the interview dialogue. I found myself doing what I was trying not to, the very thing that I felt critical of when coding. This was unavoidable. Interview texts were long and it was impractical to analyse whole texts. Additionally, I had to consider the issue of confidentiality. In order to ensure confidentiality and the non-identification of the interviewee it was necessary not only to select portions of text as opposed to using, for example, the whole interview script, but it was also necessary to be selective with regard to the sections of text chosen. I also had to change crucial identifying words, phrases and names.

Choosing a method of narrative analysis

Having identified and selected narrative data, the next stage was to choose a suitable method with which to analyse it. There were a number of methods of analysing narrative to consider. The variety of available methods may, as Richardson (2000:928) suggests, be as a result of our working in a postmodernist climate characterised by “doubt” that any method or theory has a universal claim to represent authoritative knowledge. Conventional methods are not automatically rejected as false or archaic, but are questioned, examined and opened up to new methods, which are themselves subject to critique.

The use of poetry

One of a number of new methods identified by Richardson (2000:933) is that of “poetic representation”. I was particularly interested in Richardson’s (2000:933)

comments that, "... poetry may actually better represent the speaker than the practice of quoting in prose snippets", and that "... settling words together in new configurations lets us hear, see, and *feel* the world in new dimensions. Poetry is thus a *practical* and *powerful* method for analyzing social worlds."

Indeed a number of investigators have referred to the usefulness and appropriateness of using this form of narrative presentation and analysis. Riessman (1993:19&45) refers to Gee (1985, 1986, 1991) who argues that poetry "fossilises" and ritualises what is in everyday speech. Gee (1986) is of the view that stanzas are a universal unit in planning speech and is concerned with analysing changes in pitch, pauses and features of speech which indicates the groups of lines which form them. Manning and Cullum-Swan (1994:465) also refer to how in narrative analysis, themes, principle metaphors, definitions of narrative, defining structure of stories and conclusions are often defined poetically and artistically. Coffey and Atkinson (1996:128) point out that the stylistic variation and innovation of textual representation available in narrative analysis facilitates the portrayal of the "ethnopoetics" of the everyday life under consideration. The importance of poetry in anthropological studies is emphasised by Brady (2000) who points out that it helps capture and convey the poetries and literatures of various cultures, and also helps erase some unnecessary distortions resulting from detached inquiry.

Additionally, I was intrigued by the philosophy of Wittgenstein who emphasises both the importance and limitations of language. Wittgenstein (1958: paragraph 329) saw language as the "vehicle" of thought and seems to suggest that thought and language amounts to the same thing. At the same time Wittgenstein (1965:12) suggests that language is a "cage" that constrains us, and it is necessary to go beyond its "boundaries" towards a more meaningful experience of life. In discussing Wittgenstein's ideas, Edwards (1982:211-12) refers to the problem of "literalization", the process whereby thought is limited to simple re-presentation. In order to overcome the problem of literalisation, Edwards (1982:213) refers to the power of the poetic image, which "... can help us to see the image that we usually fail to perceive in our ordinary way of seeing only the thing." Edwards (1982:213) argues that the "... poetic image deliteralizes all our seeing", and is a way of expanding our perceptions such that once we have experienced deliteralisation and the perceptual expansion that

comes with it, we can never be so complacent in our ordinary ways of seeing, feeling, and acting.

I was rather struck by some of the above ideas, particularly as it appeared to me that by fragmenting my interview texts during the process of coding I 'literalised' them. By taking pieces of text out of context I reduced the text to a collection of words. The importance of factors that went beyond words and language, such as expression, and the interview event and factors that surrounded it were ignored. I also became aware that whilst listening to recordings of interviews it was apparent that when people talk, their speech is closer to poetry than to prose. I was rather sceptical at first but decided to represent the prose transcription texts of selected narratives in a poetic format.

Method of poetic analysis

In conducting the analysis by poetic representation I followed the general guidelines of Riessman (1993:60-1) who points out that the analysis is closely linked to the transcription. Mishler (1991:277) points out that arranging the interview text is part of the analysis and involves testing, clarifying and deepening ones understanding. Riessman (1993:61) warns against reading the narrative simply for content or as evidence for a prior theory, and refers to the need to consider the cultural, social and institutional context, and issues of power. It was important, for example, to consider the way in which the interviewee relates her/his tale to the particular listener, and whose voice is represented in the final product.

I began by re-reading the prose transcriptions of interview transcripts and re-writing them in a poetic form. Additionally, I listened to the original tape recordings in order to get an authentic feel for the individuals rhythm of speech. Features of speech such as gaps, breaths, emphasis of certain words either by tone or volume, and stops, were all used to construct a poetic representation. I used the original words and only on very rare occasions were these changed, added to, or reorganised in order to clarify meaning. In accordance with Riessman (1993:61), I excluded the questions and comments made by myself as the interviewer, and I also excluded the interviewee's false starts, repetitions, exclamations and other features that obscured meaning and poetic fluency. I was careful to represent the voice of the informant in a sensitive and

meaningful way and to keep in mind the analytical purpose of the exercise. Coffey and Atkinson (1996:129) point out that there is a danger of producing emotional or aesthetic effects simply for the sake of producing them and the process may be affected by inappropriately self-indulgent displays of cleverness on the part of the author.

The effect was quite startling. The poetic representation brought the transcriptions to life, as it were. They appear vibrant and in Coffey and Atkinson's (1996:129) words are more "... illuminating and gripping than a conventional format might be." Most importantly, I was immediately struck by the way in which poetic representation led to new insights and made the content more accessible and interesting. In fact, this impression was shared by one of the interviewees. In order to test its validity I asked her to read her interview text that I had converted into a poetic representation. Her response was very positive. She said she liked the representation and that reading it "brought it all back". She felt the poetic format added to the text in that it provided a sense of suspense and she commented that you "... could really understand what was being said."

Poetic representation and findings

During the process of narrative analysis I used three columns in order to represent and analyse the narratives. The first column entitled 'prose' contained the text of the narrative presented in a prose format. The second column entitled 'poetry' contained the poetic representation of the narrative. The third column entitled 'comment' contained analysis commentary considered relevant to the topic of the investigation, that is, the ethical reasoning and decision-making of the nurse (see **appendix 11** for a full illustrative example). In the chapter on narrative analysis I have presented the narrative in a poetic format only, together with a commentary. I have done this in order that the poetic nature of the narrative can be presented in an uncluttered way.

WRITING UP

The process of presenting my findings raised a number of interesting observations and choices. First, it became immediately clear that while I had conducted both coding

and narrative analysis, the analysis was not complete and continued as I proceeded to write up. It was, as Richardson (2000:925) points out a method of discovery and analysis and not just a mopping up activity at the end of the research project. Furthermore, according to Richardson (2000:925) it was a way of finding out about my topic and myself. The way I present the research says much about me. It has, as already suggested, autobiographical features within it.

Continuing the analysis

The coding analysis continued during the process of writing up. It was necessary to reallocate some data to different categories in order to make the account more logical. As Dey (1993:237) points out, writing the account was not simply a method of reporting results but one of producing results, and the discipline required to produce an ordered, sequential and detailed account can stimulate one's thinking in fresh and original ways. The written language is an analytical tool, not a transparent medium of communication (Hammersley and Atkinson, 1995:240). The link between explaining something and understanding it is a close one for "... what you cannot explain to others, you do not understand yourself" (Dey, 1993:237).

Aims in writing up

The primary aim in writing up was to produce an account of my research that was creative, readable and engaging. It also had to be an accessible account which was clear and coherent, and unencumbered by needless digressions, convoluted arguments and distracting detail, as well as an acceptable account which was convincingly grounded conceptually and empirically, so it made sense in itself and made sense of the data (Dey, 1993:237). It was also important that the account was not boring. In fact, Richardson (2000:924-5) confesses to finding much qualitative writing boring and warns against the suppression of the writer's individual voice and sense of self as he or she is homogenised through professional socialisation by rewards and punishments into the "mechanistic model of writing". It is necessary to creatively challenge traditional thinking and according to Richardson (2000:928) we are fortunate to be working in a postmodernist climate which encourages us to do so. Postmodernism is characterised by doubt that any method or theory can claim to be

the right form of authoritative knowledge and suspects all claims to truth of "... masking and serving particular interests in local, cultural, and political struggles" (Richardson, 2000:928). This critique of traditional methods has resulted in the use of different forms of qualitative writing, that have enlarged, blurred and altered the ethnographic genre, and which Richardson (2000:929) refers to as "creative analytic practice ethnography".

Guidelines for creative writing

So how does one creatively write up? There are some guidelines. Dey (1993:238) refers to the usefulness of some of the techniques used in the art of story-telling. Story-telling requires three basic ingredients, a setting, characters and a plot, all of which requires presenting in an engaging way. It was interesting to note how my findings could be seen in this way. Clearly the setting was the ward on which the study took place, the characters were the nurses involved in the study and the plot was the social action under investigation, that is, the ethical situations and difficulties nurses faced and how they reacted and thought about them. But how was I to present this in an engaging way? A vivid and convincing description of the setting is required thereby providing an authentic context in which the characters and plot can unfold. I have commenced the account of my finding with a detailed description of the setting in a chapter entitled 'The Unethical Environment'. Additionally it is useful to empathise with one or more of the characters as this makes the story engaging to the reader who begins to care about what happens to the characters. Clearly, because of the requirement of confidentiality I have had to conceal and protect personal identities by changing names and identifying features. Despite this, I have attempted to present nurses as they really were. I have included large sections of interview narrative, and used pseudonymous first names and personal details. Finally, in a good story the plot evolves towards some form of crisis or resolution thereby gripping the reader's attention because of uncertainty about the outcome. In presenting the findings I have attempted to relate the reality of the situations as described by nurses which were often critical and gripping in themselves. The use of extensive narrative was particularly useful in this respect.

There are a number of other important considerations in creatively writing up. It is important to ensure that the account is not just an easy read but that it engages the moral attention and interest of the reader, that it is not merely abstract and academic but is rooted in the world of practical human and social concerns (Dey, 1993:239). This is an important point. It is of ethical concern that this study has a practical beneficial purpose. Other important considerations include, the need to effectively communicate by avoiding jargon and using direct and uncomplicated language (Dey, 1993:245); the need to improve quality rather than adding quantity (Dey, 1993:239), and the need to edit and review extensively in order to eliminate needless repetition and clutter (Dey, 1993:247). Hammersley and Atkinson (1995:241-2) refer to the importance of wide and eclectic reading of the works of others and the need to approach the literature in a catholic and creative way. Certainly my analysis, based on the combination of coding and narrative methods, was a result of widespread reading and subsequent awareness of different possible approaches.

RELIABILITY, VALIDITY AND REPRESENTIVITY

Throughout the research process, from data collection and analysis to writing up, it has been important to consider the issues of reliability, validity and representivity. Dey (1993:250) uses a useful analogy of a watch to explain these terms. The watch is reliable if it is consistent and goes neither fast or slow, it is valid if it tells the right time, and it is representative if it shares the same time with others in the general population.

The most convincing way of demonstrating reliability would be to have the study replicated by others. Given the impracticality of this the best I can do is to explain how I arrived at my findings (Dey, 1993:251). I have to some extent, used a process of triangulation by using different methods of data collection. I have also endeavoured to be as transparent as possible and to explain and demonstrate openly and clearly how the study was conducted, how decisions were made, and how conclusions were reached.

Regarding validity, the question is how to verify to myself and others that my account is conceptually and empirically sound and that throughout the research process I have,

to refer to Dey's analogy, been 'telling the right time'. As the sole researcher in this study I am vulnerable to charges of subjective bias. There are, it would appear, two broad defences against such charges. The first is philosophical, and the second is methodological and involves certain practicalities. The first defence is to adopt the philosophical position of embracing subjectivity as something to be recognised and understood rather than condemned as a barrier to so-called 'objectivity'. In this respect Hammersley and Atkinson (1995:16), being critical of certain features of positivism and naturalism, emphasise the importance of reflexivity and recognition of the fact that the research process is inevitably influenced by the biography of the researcher. This, Hammersley and Atkinson (1995:17) argue, does not undermine the researchers commitment to realism, but it does undermine "... naïve forms of realism which assume that knowledge must be based on some absolutely secure foundation."

The second defence against possible charges of subjective bias is methodological and involves the taking of practical measures, to adopt a series of checks in order to verify that my account agrees with that of others. This was important, for example, with regard to the interview transcriptions. In order to verify, as much as possible, the accuracy of interview transcripts, all interviewees read the transcript of their interview and where necessary made corrections. I became aware of the value of doing this as my reflective notes following the interview with Zoe demonstrates:

The importance of verifying the accuracy of the transcript has become very obvious to me. Transcribing is a process of interpretation. Sometimes what is said may not be clear. Additionally, after transcribing this interview I played the tape and read the transcription at the same time. I was surprised to find some differences despite trying to transcribe as accurately as possible. Words were included in the transcript that were not on the tape recording and visa versa. The differences were not major, but they were there and could conceivably alter meaning. In order to validate transcripts I think it is important to send a copy to the interviewees so they can comment on their accuracy. (15th February 1997)

Additionally, in order to demonstrate validity, I have to some extent triangulated my analysis by using both coding and narrative methods. I also conducted two rounds of interviews. This was in order to establish whether or not the findings from the first round of interviews were supported by the data from the second round. In order to

attain 'face' validity, where my ideas and conclusions fit the data, I have attempted to show in my writing that the empirical base for my arguments is explicit and findings are grounded in the data (Dey, 1993:256). I have also tried, as far as possible, to demonstrate construct validity, that is, the extent to which my findings concur or otherwise with those of other studies. This is limited by the fact that this area of study has been little researched.

Another method of validating my findings is the use of verisimilitude when presenting the data (Lincoln and Denzin, 1994:579). That is, I have endeavoured to use a style of writing which emphasises the "plausibility" or "*vraisemblance*" of the text (Atkinson, 1990), and draws the reader into the subjects' world to the extent that it can be "palpably felt" (Adler and Adler, 1994:381). Adler and Adler (1994:381) point out that if the writing contains internal coherence, plausibility and corresponds with what readers recognise from their own experience and from other realistic and factual texts, then the work will appear authentic. I have employed verisimilitude by using extensive verbatim quotations from transcripts. In ethnography this is useful in presenting a credible report of the research as it allows the reader to judge the quality of the work, how close the researcher is to the thoughts of "natives", and to assess whether the researcher used data appropriately to support the conclusions (Fetterman, 1998:12). Additionally, as the findings of this study have evolved, I have presented them in seminars to audiences including nurses and lecturers. In doing so I have found that there was an instant sense of recognition by members of the audience to the findings. One response was most interesting. "Has nothing changed?" asked an experienced nurse who is now a lecturer in nursing.

Finally, with regard to findings being representative, this is not necessarily an expectation of qualitative research. I did not anticipate being able to claim that my findings could be generally applied outside of the study. However, I have in writing up tried to demonstrate that my analysis and findings are well grounded in the data so that others might be more confident that my suggestions are worth pursuing (Dey, 1993:263).

ETHICAL CONSIDERATIONS

It has been important that every stage of this study has been conducted ethically. The history of research involving human subjects is replete with examples of abuse (Burns and Grove, 1995:363-6). Clearly any research involving human subjects requires careful consideration. Health authority ethics committees monitor such research in order to ensure that it is ethical and non-abusive. The local health authority's research ethics committee granted ethical approval for the study to take place.

Worthiness of the project

The first ethical consideration concerned the worthiness of the project, my reasons and motives for doing it, and whether or not it reflected my personal values (Miles and Huberman, 1994). I chose the subject of this research because I thought it was an important area of study that was relatively little researched. There existed a gap in our knowledge and research into this area would hopefully provide new knowledge and insights with the potential for social benefit. I did not perceive the study as one in which I was simply seeking knowledge, but one where the findings may have positive benefits. In this respect I differ from Hammersley and Atkinson (1995:263) who argue that "... the goal of ethnography should be the production of knowledge – not, say, the improvement of professional practice or the pursuit of political goals." I am, to some extent, sympathetic to the "partisan" ethical position identified by Silverman (1985:184) that suggests the researcher is someone who seeks to provide the theoretical and factual resources for change. Also of ethical concern was the choice of research methodology. It was essential that the chosen methodology and research design was congruent with my personal values and the research aims. If not, the study would likely fail and the time and effort of contributors wasted.

Respect

Of primary ethical concern was that the research be conducted in such a way that it was respectful to those involved, and in particular respectful of personal autonomy. The process of gaining informed consent is important in this regard (Beauchamp and Childress, 2001:77). It was essential that participation was voluntary and uncoerced

and that participants were aware that they had a right to accept or reject the invitation to participate and could withdraw their consent and cease their participation at any time. I ensured nurses were fully informed that the study was taking place. During the initial stages when I was collecting observational data I also ensured nurses were informed of this by putting a notice (**appendix 6**) to that effect on the notice board in their sitting room. Nurses were invited to speak to me if they had any concerns. If a nurse had requested not to be observed I would have respected that request. In fact, no nurse did make this request. With regard to the interviews I ensured that the consent process was formal. An information sheet (**appendix 5**) was given to each interviewee and a formal consent form (**appendix 4**) was signed. Regarding the interview I gave a full explanation which included; the purpose of the study, the purpose of the interview and an outline of what it involved, and any possible risks and benefits. I also made a commitment to confidentiality. Additionally, I explained why the interviewee had been invited to participate and tried to ensure that he or she understood the information I gave.

Respecting autonomy implied sensitivity to the wishes of participants throughout the study. There were some occasions where respecting the wishes of participating nurses was of greater importance than the study. On one occasion following a very interesting interview rich in data the nurse involved asked that it not be quoted in the writing up of any findings. I agreed with the request. During interviews difficult choices sometimes had to be made, as the following extracts from my reflective notes illustrates:

I felt I had to make some difficult decisions in this interview. How far was it right to probe? On one occasion the interviewee indicated that she did not want to say more on a topic. From my point of view it would have been useful to have explored that particular issue further. I felt I had no option but to respect the wishes of the interviewee. (15th December 1997)

Once the tape recorder had been turned off, Hilary spoke more freely about an incident which she alluded to in the interview, but which she didn't want to talk about openly when being taped. I feel I had to respect that decision and not record what she said, even though what she said was of great interest. (5th March 1999)

Finally, treating people respectfully required treating people justly. This involved treating all participants fairly, equally and non-discriminately, honouring all agreements and ensuring that participants had access to me, as the researcher, if they wished to clarify questions.

Confidentiality

It is conventional ethical practice to protect the privacy and identity of research subjects and to refrain from identifying settings and participants in order that they should not suffer harm or embarrassment as a result of the research (Punch, 1994:92). I made every effort to ensure confidentiality and privacy. I have deleted any reference to the true identity of the setting and the participants. I have given participating nurses pseudonyms and have deleted or changed identifying features in transcripts. I also had to make sure that the participant's information was not shared with others without their consent and I took special care relating to information stored electronically.

In social research confidentiality can present the researcher with difficult choices. Whilst I made a commitment to confidentiality this commitment was not absolute but conditional. I was aware that I might be faced with a moral obligation to breach confidentiality if during my observations or interviews evidence of patient abuse or malpractice, for example, came to light. I would have felt personally and, as a nurse practitioner, professionally (UKCC, 1992) obliged to report such evidence. Fortunately, such a situation did not arise, but I did discuss the possibility with the sister in charge of the ward.

Possible harm and benefits

Concern that possible harm may occur as a result of research is another important ethical consideration (Hammersley and Atkinson, 1995:268). I have already referred to the need to ensure confidentiality and privacy in this respect. There existed the possibility that interviewees may become distressed during interviews. I was very aware of this possibility and during the consent process always indicated to the interviewee that there was a risk of personal upset in discussing experiences which were found at the time to be traumatic. On occasions it was emotionally distressful for

interviewees to revisit some of their experiences as the following extract from my reflective notes written after the interview with Zoe illustrates:

I was conscious that parts of the interview had revisited a very difficult and traumatic incident for the interviewee. So much so in fact that the following day I spoke to her on the ward to ask if she was ok. Before the interview started I did warn of the risk of revisiting traumatic incidents. I am now more aware of the need to do this. (15th December 1997)

Finally, there were benefits for participants in the study. Some nurses clearly appreciated the opportunity to talk about the ethical nature of their practice and experiences. It offered nurses an opportunity to be listened to and to air their views and opinions. One of the benefits of 'insider' research is that I represented someone with the capacity to empathetically listen, understand and show concern. Indeed, some nurses said they found the interview helpful and enjoyable and thanked me for the opportunity. On a wider perspective I am hopeful that the study will offer general benefits, not only a greater understanding of the ethical nature of nursing practice but may contribute to more ethical practice and therefore better patient care.

CHAPTER THREE

THE UNETHICAL ENVIRONMENT

Having discussed the methodology used in this study, I now turn to the analysis of the findings. These are presented in the following four chapters, the first three of which present findings resulting from the coding analysis. This chapter sets the scene and analyses nurses' perceptions of the ethical nature of the ward environment in which they practised. The next chapter focuses on three substantive issues nurses identified as commonly presenting ethical difficulties. The following chapter examines the ethical reasoning and decision-making of nurses. The final chapter presenting findings presents those resulting from the narrative analysis.

To focus first on environmental factors, in analysing the findings, is consistent with the underlying assumptions of ethnography, and with my belief that the ethical reasoning and decision-making of nurses must be considered within the context in which it takes place. This chapter outlines some of the complex factors nurses felt influenced the ethical nature of the ward environment, or, to be more precise, its unethical nature, since the discussion focuses on factors that caused nurses ethical difficulties. Such factors were mainly concerned with professional relations and matters of organisation. This chapter also begins the process of informing us of the ethical experiences of nurses in this study.

This chapter consists of several sections examining: the ethical sensitivity of nurses and types of ethical experiences they encountered, professional relations between nurses and doctors, professional relations within nursing, being short-staffed and having heavy workloads, and experiences of blame and feelings of frustration. The chapter finishes with a summary and conclusion.

ETHICAL SENSITIVITY AND TYPES OF ETHICAL EXPERIENCE

Ethical sensitivity

Before presenting the ethical experiences of nurses, it is necessary to comment on the degree to which nurses were ethically sensitive, and the type and nature of the ethical experiences they identified. Moral sensitivity has been identified as the ability to recognise a moral conflict, to have a contextual and intuitive understanding of a person's vulnerable situation, and to have insight into the ethical consequences of decisions made on behalf of another (Lützén et al. 1995). Nurses in this study exhibited a high degree of ethical sensitivity. All nurses interviewed were able to talk at length about the ethics of their practice and were able to identify ethical events they had experienced or ethical issues that tended to recur. Lucy, for example, felt there had been "... hundreds of ethical issues on this ward" (L134) and best represented nurse awareness of the ethical nature of practice when she commented:

... if I am going to talk about ethical issues I could sit here till tomorrow. Because there is always ethical issues in nursing anyhow. And there is always, always going to be new dilemmas, new situations, new things to deal with. (L648)

Nurses felt they encountered ethical situations in nursing practice every day. Zoe, for example, pointed out that ethical difficulties were faced on a "daily basis" (Z42) and suggested the content of such difficulties concerned patient care, or consisted of a decision that she felt strongly about. She explained:

... it is a day to day thing and a lot of the time it doesn't stand out because it's part of your daily job of what you are doing. And then sometimes you'll get specific incidences which do stand out which generally tend to be quite major, i.e. either affecting patient care which you feel strongly about or just a decision which you have made which – not necessarily that you are right – but you feel strongly about something. (Z48)

Hilary illustrated the way in which ethics was woven into the nature of nursing practice. As an experienced sister, she explained the ethical issues around the problem of being short-staffed and then said, "... and that is ethical although I can't put it into

words. I mean, it is all ethical, it is all mixed in isn't it?" (H165) Dealing with ethical situations was so much a part of nursing practice that nurses suggested that they were involved in ethical situations much more than they sometimes realised. Sally, for example, pointed out that at the time, "... you don't realise you are making judgements and ethical decisions" (S41) and felt that she had probably made "... a lot of ethical decisions without realising or putting a name to them" (S833).

However, while nurses demonstrated ethical sensitivity, it was notable during interviews that some nurses at first doubted if they faced ethical problems. In such cases it was as the interview progressed that nurses were able to identify, describe and discuss ethical problems they experienced. Winny was a case in point. At first she felt she had not faced ethical situations (W45). However, as the interview proceeded she identified several such situations. She spoke of an ethical incident where doctors refused to document a 'not for resuscitation' decision, and referred to ethical difficulties associated with the late cancellation of patient surgery, patient discharge and planning, the shortage of nurses, and difficulties of prioritising. Val did likewise. At first she could not recall any ethical difficulties (V41), but went on to identify a number, including the issue of post-surgical patients being discharged home prematurely. There may be several reasons why some nurses at first failed to identify ethical events and issues. They may appear less noticeable to nurses because they are commonplace, and ethical difficulties may be seen not as such, but as everyday practicalities that have to be dealt. However, it may also be that the ethical sensitivity of nurses was constrained by certain environmental factors.

Types of ethical experience – ethical events, issues and dilemmas

Ethical experiences identified by nurses may be classified as ethical events, ethical issues, or ethical dilemmas. An ethical event was an incident of an ethical nature, while an ethical issue was a recurrent ethical topic. Gerri illustrated this well. When asked if she had faced situations that were ethically difficult, Gerri commented:

There are two different levels. There has been a couple of real critical incidents. A couple of those, real big things. And then there is loads of every day stuff, confidentiality, phone-calls, consent forms, informed consent and that kind of thing. (G41)

It appeared that the more experienced and senior the nurse, the more likely she or he was to identify ethical issues rather than specific incidents. This was because the nurse would have experienced similar incidents more than once. Ursula explained:

... when you are slightly more senior then you don't look at specific incidences but group them together because perhaps you've seen more than one. Just because you've been around longer and so you... tend to group things together to build up a bigger picture. (U795)

On occasions the nature of an ethical event took the form of an ethical dilemma where nurses were presented with particularly difficult choices. Ethical dilemmas took the two forms identified by Beauchamp and Childress (2001:10). In the first, there was evidence to suggest to nurses that an action was both morally right and morally wrong, and the evidence on both sides was inconclusive. In the second, nurses thought they had moral obligations that conflicted such that they at the same time ought and ought not perform a certain action.

The nature of ethical events and issues identified by nurses varied enormously. On occasions they were life or death situations that greatly affected the nurse. Zoe, for example, gave an account of having to resuscitate a terminally ill man because doctors declined to document their decision that the patient was not for resuscitation. This presented Zoe with an ethical dilemma typical of the second type identified by Beauchamp and Childress (2001) mentioned above. In the absence of a 'do not attempt resuscitation' order she was professionally obligated to resuscitate the patient, while at the same time she thought doing so denied a terminally ill patient a peaceful and dignified death. This case is discussed more fully in the following chapter.

Sometimes ethical problems did not take the form of dilemmas, but were nevertheless extremely difficult. Sally, for example, described having to deal with the unexpected cardiac arrest and death of a young man while she was on night duty. This case is presented in detail in the chapter on narrative analysis. At other times the ethical experience of nurses involved day to day issues that, while they were not dramatic, were ethical nevertheless. Zoe, for example, referred to the day to day nature of ethical problems, their significance and the stressfulness of critically evaluating them:

... I think on a day in and day out basis you face all sorts of moral and ethical decisions... Not necessarily ethical all the time but decision-making factors affecting both the people who you are caring for and the people who are caring for them. So the decisions what you make have far reaching effects, you know? So sometimes you have to make very difficult decisions but hopefully they are fair ones and they are made for the best purposes. It's like your decisions when you are in charge do affect people and sometimes you do go home and you think, "Well did I make the right one...?" You... do critically evaluate yourself if you know what I mean. And that's a day to day thing and it can be quite stressful. (Z444)

Ethical difficulties frequently arose with respect to three substantive issues, namely, the late cancellation of patient surgery, patient discharge and planning, and resuscitation. These will be considered in detail in the following chapter.

Professional relations emerged as a major influence on the ethical nature of the ward environment. Nurses spoke of ethical difficulties they faced as a result of professional relations with doctors, or as a result of professional relations within nursing.

PROFESSIONAL RELATIONS BETWEEN NURSES AND DOCTORS

While nurses spoke of good professional relations with doctors they also recited incidents that suggested relations were sometimes poor. Such poor relations were of ethical concern to nurses because they felt patient care was adversely affected. Udén et al. (1992) similarly found that Norwegian nurses often cited doctors as the source of ethical conflict. Several features relating to poor professional relations with doctors were identified as being of particular ethical concern to nurses: the use of professional power and hierarchical decision-making, difficulties in communications, and seeing the professional relationship with doctors as one of "them and us". An examination of these features helps illustrate aspects of organisation and culture that constituted the unethical environment.

Professional power and hierarchical decision-making

Professional power and hierarchical decision-making were important features in the

professional relationship between nurses and doctors. Doctors appeared to be professionally powerful and were in many circumstances the institutional decision-makers. Much of the interaction between nurses and doctors could be understood in terms of various theories of power. Power can be seen in two simple forms, as authority when it is exercised legitimately and as coercive when it is not accepted as legitimate (Wilkinson, 1999:7). Nurses felt there were occasions when doctors used power coercively. Such situations were characterised by nurses thinking that doctors made decisions that were not in the best interest of patients, or that they exercised power in their own interests. Under such circumstances nurses did not accept the professional power of doctors as legitimate.

Power is characterised by Weber (1948:180), as the realisation of individual will in communal action even against the resistance of others. Wilkinson (1999:8) points out that according to Weber (1948) those who hold power use it to their own ends. Though this may be an extreme proposition and indeed unfair on doctors who took decisions in good faith, there were a number of areas where nurses struggled against hierarchical decision-making they felt contrary to the best interests of patients. For purposes of illustration, I have chosen three: prescribing patient medications, wound care, and the reluctance of doctors to consult or refer patients to other specialists.

Prescribing patient medications

Doctors were professionally responsible for prescribing patient medication and on occasions their decisions caused nurses ethical difficulties. Here I will give two examples. In both examples the ethical concern of nurses was patient-centred and their actions motivated by the wish to act in the best interests of patients and to keep them from harm. This motivation is suggestive of the principles of beneficence and non-maleficence, the moral obligation to do or promote good, and to prevent or remove harm (Beauchamp and Childress, 2001:113).

In the first example Tina spoke at length of an experience she had where doctors failed to prescribe adequate analgesia for a patient in pain. Tina, as an experienced nurse, was faced with a situation where a patient was suffering pain, nurses were upset because they could not relieve the patient's pain, and doctors would not respond

to the request of nurses that they prescribe adequate analgesia. Doctors failed to prescribe appropriate analgesia even after Tina had spoken to the registrar. Tina was so concerned that she eventually went “behind the doctors’ backs” and contacted the consultant responsible. She explained:

The poor gentleman was in a lot of pain. It was... more than uncomfortable for the nurses to look after him... I could see that they didn’t want to look after him because they were becoming quite upset by the fact that he was in pain and there was very little that they could give him to make life easier for him and them. His wife didn’t appear to be fully grasping the situation in that I don’t think that she understood that he wasn’t going to get out of hospital. And my feeling was... that he was not getting the full care that he deserved and was in pain where he needn’t have been in pain. You hear people say that you wouldn’t even let your dog go through that sort of pain. And the nurse in charge at the time said that they’d requested that the doctor come up and prescribe stronger analgesic for this gentleman which hadn’t been done. After probably about six or seven hours the gentleman was still in pain and this had been escalating for about five days and it just got to a peak where I felt I’ve got to do something about this. So I spoke to the registrar who said that, yes they were coming up and they were going to review him and I explained that it seemed that this hadn’t been done and I was very concerned about the gentleman. So I thought there was nothing else for it but to ring the consultant which is always in a NHS trust not the easiest thing to do because you feel like they may be too busy for your call... I spoke to the consultant and explained the situation and said that I wasn’t happy with the gentleman’s care. He was obviously in need of stronger painkillers and the consultant said, “Tell my team that you have spoken to me and they need to write up some strong painkillers.” And I think I am right in saying that I can quote him in saying, “If they don’t play ball get back to me.” Which is what I did. At this stage it was about six o’clock in the evening. I phoned the doctors who assured me that they would come up... And in fact by the morning I came on the ward to find the consultant himself with his team and I introduced myself to the consultant and the consultant said, “I see that it still hadn’t been done by the morning.” But in fact there and then they wrote up some diamorphine or something like that... I just felt that these nurses were struggling on, looking after this patient when they needn’t do that and the patient himself needn’t have been in so much pain. They were actually trying to achieve something... achieve better health when there was no way he was going to get better. He was dying in front of them and this isn’t the situation or the ward where they are used to seeing patients like this... And also as I say, to then ring up the consultant, I felt like I was going behind the doctors’ backs. However in retrospect you think, “Well I gave them a chance type of thing.” The fear is after you have spoken to the consultant, the registrar or the house officer will come, and imagine yourself being pinned to the wall by them saying, “Who gave you the

right to ring the consultant?" because it doesn't look very good on them. So, I think that is a dilemma. (T72)

Despite the fact that the consultant responded positively to Tina's representations, the patient was not prescribed adequate analgesia until more than twelve hours after Tina contacted him. Tina's experience highlights the significance of power relations between nurses and doctors. She spoke of her difficulty, in a hierarchical setting, in contacting the consultant and the fact that she feared repercussions from the consultant's team for having done so. Her account suggests the consultant was prepared to listen to her and consider her professional opinion, but the more junior doctors were not. Holm (1995b) similarly found that Danish consultants were more likely to include nurses in withdrawal of treatment decisions than more junior doctors because they were perceived as less of a threat to their authority. Significantly, Tina resisted institutional and professional power and took action she thought was in the best interest of the patient.

The second example involved Lucy who spoke of her wish to relieve the anxiety suffered by patients prior to cardiac surgery and the unwillingness of doctors to prescribe night sedation for them despite her requests. She explained:

... you have a patient who is coming in for surgery, he's really anxious. And we very often get patients that are anxious about their surgery because they are having a massive heart surgery. It is not as if you are just having your finger repaired. It's actually to do with your heart and some patients don't make it through. And it is such a big thing for them. And they come in and they are nearly crying to you when you are giving them information. And you can see how anxious they are. And you ask the doctors if they would please prescribe some Temazepam or something for them to give them a nice comfortable sleep at least, so they won't stay awake all night just worrying about the surgery the following day. And some of the doctors don't write up the Temazepam. They say, "O, well no, we will leave that up to the anaesthetist" and, "O no I don't think that is appropriate" etc, and, "O no, I don't think I want to do that." Or they say, "Yes, I'm going to do that" and they arrive on the ward at two o'clock in the morning. And I think that is just one of many examples again. And you are left there and you can't really take a verbal message on the phone. You know, when you can give the patient anything at all. And the patient is sitting there literally begging you for something so he could have a good comfortable sleep because he is so anxious. And you are just trapped in the middle again. There is many situations like that occurring. (L421)

In Lucy's comments there is a sense of empathetic understanding for the patient's situation, and a feeling of powerlessness at the inaction of doctors and her inability to meet the needs of the patient. This was a situation where, like many nurses, Lucy felt "trapped" between the patient and the doctor.

The responses of Tina and Lucy to the professional power of doctors in the two examples differed. According to Clegg (1989:210) power and resistance stand in relation to each other and it is rare to have one without the other. To some extent resistance may have depended on certain qualities of character possessed by the nurse involved, such as confidence, and on personal attributes, such as the level of professional experience. In the first example Tina, as an experienced nurse, was able to resist the professional power of doctors. However, in the second example Lucy, as an inexperienced nurse, felt powerless.

Care of patients' wounds

The issue of wound care also illustrated the relations of power that existed between nurses and doctors and the hierarchical nature of decision-making. Wound care was an issue often raised by nurses as an area of ethical concern and possible conflict with doctors. As with prescribing medications, the ethical concerns of nurses were patient-centred, and their actions motivated by a wish to act in the best interests of patients and ensure their safety. Their concerns also reflected a belief that some decisions made by doctors were not in the best interests of patients. I will here give two examples, both of which involve the subject of wound irrigation.

The first involved nurses being requested by doctors to administer Betadine for the purpose of wound irrigation. Both Jane and Pat referred to this issue, and Jane spoke at length about it. She resisted pressure from doctors "arguing" with her. Concern for the patient was her central consideration. Jane explained:

Just last week a patient was on Betadine irrigation. Now, it's an unlicensed thing. We are not supposed to have anything to do with it. And the doctors didn't want to hear that. They don't see why we can't do it. And we said, "No, we phoned pharmacy and pharmacy said that we

shouldn't have anything to do with it. It is not in our policy and we are not going to do it." And two of the doctors were arguing with me and saying, "I don't see why you can't do it." And I said, "Look, at the end of the day with all this argument there is a patient, so make your mind up. Do you want this patient to continue on this Betadine irrigation or not? If you do, you've got to do it. We are not allowed to do it." They said, "O, we phoned the pharmacy and the pharmacy said that you can do it"... I said, "No, we have already spoken to the pharmacy... we had already asked about it and they said that we were not allowed to do it." And she said, "Well you are allowed to do it, but it is up to you if you want to." And I said, "Well, I don't want to. So can you do it?" And it was a big hoo-ha on the ward about Betadine irrigation. They want to prescribe it but they want to leave the responsibility to the nurses. And that happens a lot. You get doctors saying, "O, he is not my patient, it's his patient." And it is like you're banging your head against a brick wall and you have to say, "Look, at the end of the day there is a patient, you know, so can you make some decision." That happened with the last set of doctors actually because there was some rows going on between them and this one wasn't doing anything for this one patient and that one wasn't, and I thought, you know, "You people are getting on like kids because at the end of the day there is a patient between all this." (J609)

Jane's comments illustrate the difficulties nurses faced when disharmony existed within or between medical teams, particularly as decisions were dependent on doctors. Poor relations between medical teams and a reluctance to refer patients to other specialists were issues often raised by nurses. Significantly, Jane resisted the pressure of doctors in this incident, and her method of doing so was to refer to procedural policy. As Betadine was an unlicensed preparation it was not official policy for nurses to administer it in the way requested.

Pat also referred to the issue of using Betadine in wound care. She was particularly concerned at the reluctance of doctors to consult the Tissue Viability Nurse, a specialist in wound care. Pat felt the Tissue Viability Nurse would have given wound care advice that was best for the patient irrespective of doctors' instructions. She commented:

The doctors come along and say, "O, stick this in" and they usually say put some Betadine soaks, gauze, in it, which isn't necessarily the best thing for the wound. And we want the Tissue Viability Nurse to come along and see the patient but the doctors don't like the Tissue Viability Nurse for some reason. It is up to us to dress the wound at the end of the day but we have to make a decision whether to use the one the doctors told us to use even though we might not think that is the best thing for the

wound. And I mean you are compromising patient care at the end of the day if you're not putting what is best for the wound in there. I personally end up putting what I think is best for the wound in there, even going against what the doctors said. If we manage to get the Tissue Viability Nurse to see them I will take notice of her but it's quite hard to know what to use when I don't know whether the doctors base their findings on research 'cos the nurses do. They look at the different kinds of dressings that are on the market. (P59)

Like Jane, Pat resisted doctors' instructions she considered not in the best interests of patients. Pat felt it was important to administer wound care clinically best for the patient, irrespective of doctors' instructions. She felt it was important to take advice from the clinical specialist, the Tissue Viability Nurse, and to consider the research evidence for wound treatment.

The second example of professional power and hierarchical decision-making in relation to the care of patients' wounds concerned nurses being requested by doctors to use hydrogen peroxide as irrigation in wound care. Tina spoke of an incident that occurred in another hospital but is relevant to the discussion. She explained how nurses refused to administer the hydrogen peroxide irrigation and referred to the need for nurses to have the personal quality of "courage" in doing so. Doctors were dismissive of nursing research and Tina referred to a "battle" for its recognition. Tina explained:

... it kind of ties in with what I am talking about, having the courage of your convictions. This was actually an incident that occurred... at [another hospital]... A lady had an open sternal wound and the consultant prescribed irrigation with hydrogen peroxide, which the nursing staff refused to do. The consultant said that he wanted it done three times a day and the nurses refused to do it and he said, "Ok I'll get the doctors to do it then." What the sister on the ward said was, "I'd like to have a meeting with you and explain why we don't agree with doing this." I wasn't at the meeting but the impression I got afterwards was that the consultant... did not feel that the results of the nursing research about hydrogen peroxide was warranted a great deal of effect in that situation. He just didn't seem ready to accept those results because... it was nursing research rather than medical research. And you feel like it is a battle. But I think that was a good example because the nurses stood by what they said, they had research findings to back up their rationale although he still didn't really agree with it. (T232)

In the event, house officers administered the irrigation but in doing so the patient was exposed to possible harm. Tina continued:

... problems existed because we'd get the patient ready exposed and so not hindering the process, but of course that lady would lie there, the wound exposed maybe for an hour or more, lowering the temperature, etc, waiting for the doctors to come and do it. It was quite farcical in the end. (T255)

Tina's example illustrates the relationship between knowledge and power. Foucault (1977:27) argues that power relations are exercised through respective fields of knowledge. As a consequence any challenge to such knowledge may be seen as a challenge to professional power. In Tina's example, like that of Jane and Pat, nurses resisted institutional and professional power. Despite hierarchical decision-making and pressure from doctors, nurses chose to take beneficent actions they thought in the best interests of patients and, as Tina pointed out, this required courage.

Reluctance of doctors to consult other specialists

Nurses referred to the ethical difficulties when they felt the failure of doctors to consult or refer patients to other professional specialists was contrary to the best interests of patients. On occasions doctors failed to consult nurse specialists or other teams of specialist doctors.

With regard to doctors consulting nurse specialists, we have already seen how Pat observed that doctors would not consult the Tissue Viability Nurse. In fact, she pointed out that doctors openly said they did not want their patients to be seen by the Tissue Viability Nurse (P74). The Tissue Viability Nurse was not the only nurse specialist that doctors were reluctant to consult. Pat was also concerned that doctors would instruct nurses that a patient be permitted to eat, without waiting for the Speech Therapist's assessment of the patient's gag reflex (P100&134). She felt this was potentially harmful for the patient as any attempt to feed a patient orally before the return of a gag reflex could result in the patient aspirating. Pat summed up the difficulties for nurses caused by the reluctance of doctors to consult other

professionals, "... we are the ones doing the wounds and we are the ones feeding the patients and it is hard for us to know what to do" (P117).

Nurses spoke of situations where doctors were reluctant to consult other specialist teams of doctors or to transfer patients to other specialist areas. This caused nurses ethical difficulties because they felt patient care and treatment suffered as a consequence. Mandy, for example, thought certain patients were kept on the ward when they would have received more appropriate care in another specialist area. She spoke of a patient with cancer:

She was terminally ill and she shouldn't even have been on here really in the first place. I mean, you've got cardio-thoracic patients on here and yes she had been a thoracic but there was nothing more that we could do that an oncology ward couldn't have done better... Another issue was just getting patients transferred. They are just so slow at doing it. She'd have received better care on an oncology ward because they know more about what they are doing. You know they are trained more in that area. (M137)

Jane also referred to poor co-operation between teams of specialist doctors and the detrimental effect this had on patients. She recalled the example of a cardio-thoracic patient who had developed gastric and nutritional problems following surgery. Jane was concerned that the lack of co-operation between the teams put the patient at risk. Her example is worth referring to at length. It is particularly vivid in its portrayal of the lack of co-operation and conflict between cardio-thoracic and gastric surgical teams and it clearly represents the difficulties faced by nurses when confronted with such situations. Jane commented:

... the gastro-doctors, do you remember Bill Smith, who was here for a long time? The doctors were going at each other's throat because the gastro-people wanted Bill Smith. But they were coming over almost every day to see Bill and... when they sort of asked for something to be done, the surgical team would, sort of, go against it... And... they weren't working together. They were working separately. And in fact I thought that Bill would have died because of that. One day the consultant came up on the ward and he was really angry and he was saying... this, that and the other hadn't been done, and we were supposed to do the U&Es on Bill every day and they weren't doing it. And all that. And I said, "Can I make a suggestion? Cardio-thoracic wise Bill is ok. Why don't you take him over to the other side?" And they said, "We would

gladly do that.” But the surgeons wouldn’t let go. They won’t let go at all. And so they did say, “Well you know, we are quite prepared to take Bill over and sort him out.” But the surgeons felt, “Well we started this. We have to see it through to the end. We are not going to let Bill go.” And there was conflict all the time between the surgeons and the gastro doctors. And at one point Bill’s friend was planning to sue them. And I wouldn’t be surprised if that is still in the process because he was mishandled a lot... at one point he was I think about two weeks without any feed. Because they had to put a PEG in and it wasn’t done and, you know, he was getting weaker and thinner and a lot of things, you know, the surgeons wouldn’t listen to what the gastric people had to say. And I had them in the office with me and they were screaming at each other. And this happens, I mean, not only, it’s things like, if you ask a doctor to do something for a patient and it’s an emergency, “O, it’s not my patient.” And it’s like, they would be arguing. (J584)

When asked if she felt the behaviour of the doctors involved was unethical, Jane replied:

Yes, because it came to a point that at one time they were having a slanging match in the corridor. And Bill could actually hear them. And I had to say to them, “Look, I don’t think this is right. Can we go somewhere more convenient than standing in the corridor?” And... I just remember another incident. A patient came here on this ward and he came for an angiogram and it was a repeat angiogram. The cardiologist said that it is not them to clerk the patient and the surgeons saying it is not them because the surgeons say they can’t give the patient proper information because they don’t know for the patient to sign the consent. And it should be a cardiologist. And the cardiologists were saying that they have done an angiogram on that patient already and if the surgeons want a repeat one, they should consent it. And this patient was standing in the corridor and this one was saying, “It’s not my patient, it’s not my patient, it’s not patient.” I had to pull them apart and say, “Look, can you come to the office to discuss this because this patient is standing there and listening to all this. And, you know, it doesn’t make him feel any. He is probably saying, ‘What place am I in?’” Anyway, it happens... frequently. (J671)

Jane’s concerns, in both incidents she referred to, are patient-centred. She took actions she thought were in the best interest of the patients and designed to keep them from harm. In the first she suggested the patient be transferred to the gastric doctors and in the second she attempted to shield the patient from witnessing the disagreement amongst the doctors.

Nurses offered a number of reasons as to why they thought doctors were reluctant to

consult other specialists or to refer patients. Mandy thought it was due to laziness. She commented, "I think a lot of it is to do because they can't be bothered to walk over to the ward, to be honest. But I mean, I probably shouldn't say that but that's how I feel" (M159). She also thought doctors were reluctant to admit defeat and, like Jane referred, to the case of Bill Smith. Mandy commented:

... we have had one case... where the surgeons haven't dealt with the situation properly and its got worse and become say, a gastro problem. They are just reluctant to refer on because they don't want to admit defeat, if you like... and I feel this particular patient, if it had been me I would have sued them. I'd have sued them because he was just ill far too long. If they had just referred him over and admitted, you know, they had done something wrong or whatever, the problem would have been dealt with and put him through a lot less misery. Because he went through a lot really. (M440)

Hilary speculated that doctors were reluctant to refer their patients because they faced organisational pressures. It can take time and this may lengthen a patient's stay in hospital. The implication also being that they may block a bed and prevent the admission of another surgical patient. Hilary commented:

I think it depends on the problem. I find that if it is a diabetic problem and the patient was a non-insulin diabetic and now becomes an insulin dependent diabetic, in my past experience we have often referred them to the diabetic team, the metabolic team, or the endocrine team. There seems to be here a reluctance because I think it is felt that it would take ages for that team to come and see them and that would increase their length of stay in hospital. And I think they are often sent home with, "O, go to your GP to sort out your diabetes when you get home." If the patient is surgical and they've got a cardiology problem I think the cardio-thoracic team will half-heartedly try to sort the problem out and then will ask for the cardiologists to come in. But it always seems to take a long time before the cardiologist comes to see the patient. Whether it is the same when the cardiologists are referring a patient to the surgeons, I'm not sure, as I'm very surgical. I think that other problems that they don't have much idea about or if it is an obvious renal problem I think they are quicker to refer them to the renal team. (H283)

There may indeed be a number of reasons why doctors were reluctant to consult other specialists. However, the ethical difficulties experienced by nurses when doctors declined to consult or refer patients to other specialists may also be seen as another example illustrating the relationship between knowledge and professional power. That

is, doctors attempted to maintain power and control by declining to recognise the knowledge of others. Mackay (1989:41) found that some doctors were reluctant to admit that in some areas nurses had greater knowledge than they did. Fox (1992) showed how different professional groups involved in the practice of surgery held tenuous power dependent on their ability to demonstrate knowledge that was instrumentally valuable and capable of legitimately defining patients.

Finally, with regard to the relationship between teams of specialist doctors, Hilary referred to communication difficulties that sometimes occurred and the way in which this caused confusion and misunderstanding for the patient who would then complain to the nurse. Hilary commented:

I sometimes think when more than one team is involved there's terrible communication problems between two lots of medical staff. For instance, maybe someone is under the cardio-thoracic surgeons but is also under the renal team... and they don't talk to each other particularly. They pass messages via the notes or via the nursing staff. One will tell the patient one thing, the other team will tell the patient another thing. And the patients often complain about a lack of communication. I don't mean they send in written complaints but they do sometimes say to the nursing staff, "They've come round on the ward-round today and they have said this, and yesterday they said I could go home on Friday, today they said I could go home on Tuesday. One said I needed anti-biotics the other one said I didn't." Those kind of things, they frequently say that. And because different members of the same team come round at different times they get a lot of conflicting information. I suppose that is ethical. (H266)

Hilary's concern was that patients may in some way be harmed. They may become confused and anxious when given conflicting advice, information and treatment and as a result may lose confidence in both the care given and those providing it.

Professional communications

While some nurses spoke of good professional communications with doctors, others referred to such communications as poor and, as they might negatively affect patient care a source of ethical difficulties. Their comments on this topic varied, as nurses also spoke of good communications. Professional power and hierarchy was influential, and to some extent communications between nurses and doctors depended

on the seniority of the nurse. Communication between doctor and nurse improved the higher the grade of the nurse. As a consequence lower grade nurses tended to have little communication with doctors and some felt sidelined and devalued. Their opinion was usually not sought and they were simply expected to do menial tasks. For example, when Gerri, a newly qualified staff nurse, was asked if she had much communication with doctors, she commented:

I don't think at my grade there is. Well I know there isn't. But I do think that there must be more discussion between the 'F' grades and the Regs. I think there is more input there. Purely because they see themselves on a more of a, kind of, same kind of peer group thing. You know, more of a par. [Newly qualified staff nurses] are, kind of, too lowly to discuss anything like that, you know. We are just, you know, "Give them this pill or take that sample." (G354)

Nurses faced difficulties when they required a doctor and none were available. Ursula pointed out that medical staff were not easy to get hold of at night (U105) and Quincy referred to the difficulties that could arise when experienced doctors were in theatre and only a relatively junior doctor was available on the ward (Q530). Pat referred to the same problem and pointed out that it was difficult for nurses to make decisions when they were unable to contact doctors. She commented:

... there is supposed to be one on the ward everyday and one in theatre. It has been a bit better recently, but the last set of SHOs we had there was never anyone on the ward. I don't think they particularly liked working on [the ward]. There is quite menial jobs for them to do up here, writing TTAs and bits and bobs really. I think they prefer it down stairs, which is fair enough, but they still need to do it. You could never get hold of them for the little things. That's part of the environment which makes it quite difficult to make any decisions, if you can't get hold of the doctors. The relationship between the nurses and the doctors has got better as well. But that didn't used to be all that great because of the fact that we had been moaning at them because we couldn't get hold of them and they wouldn't do what we asked them and they didn't want to do it and they were fed up with us moaning at them. But it has got a lot better since we've had a new lot of SHOs. (P404)

Notably, Pat felt good communications with doctors depended to some extent on the character and personality of doctors. As a result the quality of communications between the two professional groups might vary as doctors rotated their posts.

The issue of documentation was considered by nurses to be an important feature of communication with doctors and one that sometimes caused ethical difficulties. Hilary, for example, felt on occasions doctors failed to inform nurses of their decisions concerning patient care and treatment. She commented:

I think there are problems with communications between doctors and nurses... I think sometimes some of the senior surgeons or doctors will go and see a patient and say, "Right, we are going to do this, this, and this." And they don't write it anywhere or don't say anything to the nursing staff and we are all surprised when a chair arrives to take the patient to somewhere. (H300)

Hilary, as a ward sister, thought communication between doctors and nurses was not "too bad" (H305). Winny also referred to the issue of documentation. She felt the medical team did not always keep medical notes updated and this caused problems for nurses because when they wanted to check something in the notes it was not always documented (W233). Overall, Winny a ward sister, like Hilary, felt nurses were kept adequately informed and that communication was good (W250). However, not all senior nurses felt communications were good. Yvonne, another ward sister thought most of the daily problems she faced were due to poor communication between nurses and doctors and differences in priorities between the two professions (Y362). Xaria, from the perspective of a very junior nurse, agreed with Yvonne. She felt doctors and nursing management failed to communicate enough with each other, that they acted separately and that it would make a difference if they could act more as a team (X300).

The ward-round was an important organisational event involving professional communication between nurses and doctors. However, nurses referred to ethical difficulties as a result of the nature of communications during ward-rounds.

Ward-rounds

Nurses often referred to the issue of doctors' ward-rounds. During weekdays two ward-rounds normally took place. The first was just before 8.00 in the morning prior to doctors going to theatre and the second occurred in the evening when surgery had finished. Ward-rounds were important for communication between doctor, nurse and

patient. Professional power and hierarchy was again influential, and perceptions of the value of ward-rounds as a means of communication varied depending on the seniority of the nurse. Both Hilary and Winny, as experienced ward sisters, spoke of their value. Hilary emphasised their use as a means of exchanging information (H306), and Winny thought the two ward-rounds contributed to what she thought was good communication between nurses and doctors (W250). Yet many nurses, particularly junior nurses, identified them as ethically problematic. Some thought that in reality ward-rounds were rushed affairs where communication was limited and the patient often ignored. Xaria, for example, recalled her experiences as a newly qualified nurse and graphically described the nature of the typical ward-round:

I used to go around on ward-rounds with the doctors in the morning. I'd stand there with my pen and paper waiting to write things down and they would have seen three patients in that time. I'm thinking, "Well what did you decide?" You know, they talk amongst themselves. It's sometimes as if I'm not there. I admittedly say there are some doctors that will talk to us or talk to me, talk to me personally and say, "Well Xaria, what do you think?" Then you are taken aback and you think, "O, my god." You know, but yea, there's differences in the way the teams see them. The doctors, they wizz around. I don't know whether it's time they've got or what, or whether they know that patient so well, you know. They wizz around so quickly. I feel the patient hasn't got time to say anything. We do encourage the patients to talk to the doctors. I do anyway. I say, "Mention it on the ward-round in the morning, you have to tell the doctor." I think the patients are taken aback because how quickly they talk and a lot of the time they don't talk to the patient. They talk about him, to each other, but not to the patient. (X343)

Xaria was concerned not only at the lack of communication between herself and doctors but also at the doctors' lack of communication with patients and the fact that patients were not given the opportunity to ask questions. Mandy, as another newly qualified nurse, felt likewise. Her experience of ward-rounds was similar and she was particularly concerned at the effect on patients. Mandy thought ward-rounds were so hurried that doctors failed to examine the patient properly, to listen to patients, and to inform them about their treatment. She commented:

Well, they come at about a quarter to eight and do the round and the surgery starts at eight... in my opinion when they do a round they should look at the whole patient, look at their wounds... I mean, yea, we tell them if something is wrong but I think they should look... You know,

they are just so quick and very often they don't listen to the patients a lot of the time. They don't even ask them sometimes... they are hurried. I mean, very hurried. You get... people who have been cancelled and they are... waiting a few days on the ward and they [say], "They've just walked straight pass me and I don't know what is going on. They have just walked straight pass me again." It only takes a civil word to them really to let them know what is going on but they just walk straight pass. (M259)

Gerri, another newly qualified nurse, also thought there was little discussion between doctors and nurses regarding patient treatment, and that doctors failed to give patients the opportunity on ward-rounds to ask questions. She commented:

Because on here I don't think there is the opportunity. If you see a doctor twice a day on here you're very lucky and privileged. And the doctor's round as well, is an absolute prime example. They come on here at, what, five to eight, they shoot round at ninety miles an hour and if any patient dares to question anything they're like, "Ok, yes, Mr Bloggs, thank you very much." You know, classic ending the conversation, you know, before it started. And that's it. That's the only opportunity you get to meet with the doctors really. They might pop up for five minutes, you know. (G367)

Zoe, a more experienced staff nurse, felt the absence of a full time doctor on the ward was the fundamental problem. She referred to the brevity of ward-rounds and the frustration felt by nurses that they were unable to discuss the patient's care:

I think the fundamental problem is the system on here where you don't have a doctor working on the ward full time. And you have a doctors' ward-round that lasts about ten minutes before they all rush off to surgery. There is not enough time to really discuss fundamental issues of basic nursing care or make decisions about patient care... so for a lot of the time you are quite frustrated, in fact, very frustrated on this particular ward. (Z119)

Zoe represented the wishes of many nurses when she referred to the need to start "talking" and for regular meetings between nurses and doctors to discuss care and treatment (Z410). She also explained that attempts had been made to improve ward-rounds but both doctors and nurses were working under restraints such as high workload, lack of time and a lack of managerial will. Zoe commented:

I don't know how you would resolve it on a ward like this. We have tried several times to have a more effective ward-round but as I say they work with their hands tied behind their back as well. But their directive comes from above as well... They have limited time, but as I said the directive comes from the top and you have consultants who don't even do ward-rounds themselves. They never actually come on the ward and do a ward-round. So that starts from the top downwards, if you know what I mean. They are a busy team. But I don't see why. After a day of surgery a consultant should come round. And even if it's only a half-hour ward-round a consultant himself, you know, that doesn't happen... Well it's like I say you're talking about relationships and teamwork on the ward. To do that all stems from management from both sides, and the environment that's created. (Z368)

While high workloads and lack of time contributed to the rushed nature of ward-rounds, the accounts given by nurses appear to support the view that the ward-round is an organisational event that contains power relationships. In a post-modern analysis of ward-rounds, Fox (1993:50-59) argues that while they give the patient an opportunity to challenge the surgical discourse that views them as unresisting subjects, surgeons organise these interactions reactively in order to minimise this challenge and to maintain their power.

'Them and us'

There existed amongst nurses a view that professional relations with doctors was a matter of 'them and us', rather than a team working in the interests of patients. This was of ethical concern to nurses because they thought patient care was adversely affected. Mandy clearly illustrated this perception of 'them and us' when discussing the issues of patient discharge. She referred to surgeons and remarked:

I mean, it's like them and us. It really is. They just don't seem to listen. We have a man with a wound at the minute. All we are doing is dressing it every day... I brought this up and I said... this is nothing that a district nurse cannot do. And you just get back, "Yes, but this wound might breakdown and they need to be here really." But, a district nurse can see that, you know. (M191)

Gerri also felt that there was a lack of teamwork between nurses and doctors on the ward and commented:

On this particular ward I don't think there is a team effort... I think it is very much the two sides. I often feel we are battling against each other. That changes with the different doctors with the different personalities... I think our last lot were more of a team. We... got together more with them. We went out socially with them and stuff like that. But again we have gone back to the 'them and us,' you know. "God, they're useless"... and they think we are useless, kind of thing, you know. I don't think there is much team spirit... I think a lot of wards have got it, they've got the team thing going on. But I think on here it is very much, they're on their side and we're on ours. (G502)

Gerri referred to a lack of trust in each other's abilities as characteristic of poor working relations between nurses and doctors. She also felt professional relations were dependent on the personalities of those involved. There existed a six monthly rotation of doctors with the result that professional relations were subject to regular change. Professional relations between nurses and doctors therefore varied and were dependent on the doctors allocated to the ward at any one time. Lucy felt that the six-month rotation of doctors made it hard for them to settle in and it was hard for nurses to get used to them. She felt that one set of doctors were particularly slack and illustrated how patient care could be negatively affected. Lucy referred to an incident where nurses were trying to get doctors to refer a patient who was terminally ill with cancer to the oncologists. She commented:

We kept on nagging the doctors... and they were more concerned about the patient that was going to theatre who was fit and well... And we had an awful lot of complaints written all the time [at] that period about the doctors... they were very slack, they never seemed to do patient's TTAs, etc, when they were going home... We kept on having to hang onto patients while the relatives were waiting out in the car and not being able to send them home because they didn't have their TTAs... they were really, really slack that particular lot of doctors... (L204)

Nurses spoke of incidents that suggested a complete breakdown of functional professional relations with doctors. Incidents of verbal abuse by doctors worsened relations between the two professional groups. Gerri witnessed one such occasion and graphically described what happened:

There was one afternoon where an 'E' grade was in charge. There was one doctor available. He wasn't in theatre and he wasn't in clinic, so he was covering the three wards. And there was just several things that kept coming up that she needed to liaise with him. And on the last phone-call,

he rang her up and told her, “Stop f...ing phoning him. If she f...ing phoned him again he would come up here and sort her out because he was f...ing fed up with being f...ing called all the time. What did you think he was f...ing doing, drinking coffee?” And slammed the phone down on her. Unfortunately she was too shocked to do anything about it. She should have reported it there and then to the duty manager, but she didn’t... you don’t expect that from them. (G519)

Gerri continued by referring to another incident involving the same nurse. On this occasion the doctor did not use foul language but did shout at the nurse in front of patients. This time the nurse took the matter further. She reported the incident and was supported in doing so by nurse management. Gerri commented:

Hmm, similar to that happened quite a lot with that particular lot of doctors and with that particular doctor as well... There was an incident on the ward where a doctor didn’t use foul language but was basically shouting and having a go, for want of a better word... The doctor wanted to get a patient over from [the infection control ward] who wasn’t classified as clear of infection. And the ‘E’ grade was saying, “Well no. What’s the point of her being over there in the first place to bring her back here still possibly with this infection?” And this doctor didn’t like it. And was shouting at her in the corridor in front of all the patients. And this time she’s reported it. And she’s got support from top people. (G553)

That nurses viewed doctors as a source of ethical difficulties was perhaps best illustrated by the fact that they kept a ‘doctors’ incidents book’ in which they documented poor practice as evidence. Gerri commented:

... last year or so, we had a book, the ‘doctor’s incidents’... Because the doctors were continually disappearing or leaving people in agony, not filling in TTA forms, ringing up and abusing nurses and using all sorts of foul language and stuff, we had a book. So we were writing down all these incidents to take it to the consultants just to say, “This isn’t on.” (G502)

PROFESSIONAL RELATIONS WITHIN NURSING

As well as professional relations with doctors, nurses also identified professional relations within nursing as a source of ethical difficulties. Power relations and hierarchy were as much features of professional relations within nursing as they were in professional relations between nurses and doctors. Nurses identified such relations

as ethically problematic because they adversely affected patient care. According to Miers (1999:67) there is substantial evidence to suggest that nurses negatively experience working in the hierarchical structure of nursing. Two issues, lack of professional support and communication problems, stood out as being most important.

Lack of professional support

While nurses spoke of situations where they thought they had been professionally well supported by nurse managers and senior nurses, they also recited incidents where they felt unsupported and as a result experienced ethical difficulties. Lucy, for example, felt most ethical difficulties faced by nurses were caused by a lack of support from doctors or nurse management (L419). Nurses recalled incidents that illustrated a lack of support amongst nurses at different hierarchical levels. I will give three examples, the first where a ward sister felt unsupported by nurse management, the second where a junior nurse felt unsupported by the nurse in charge, and the third, the issue of new nurses feeling unsupported and ill-treated.

Nurse management

The first example involved Ursula, who as a ward sister, felt unsupported by nurse management over an incident where she and other nurses objected to a request by doctors that a terminally ill patient who was close to death be transferred back to his referring hospital (U666). Nurses thought it was not in the patient's best interests to be transferred. However, doctors felt that as the patient had been referred to them for a medical opinion, he should be transferred back to the hospital he came from. In their clinical judgement they could do nothing for the patient and felt doctors at the patient's referring hospital would be more able to treat his medical condition. While Ursula respected this point of view, she and other nurses thought he was too ill to be transferred. She thought transferring the patient disrespected his dignity and privacy and possibly his autonomy as well. She also considered the interests of the patient's relatives. Ursula explained why she felt the patient should not be transferred:

... when somebody's ill you're not really respecting their dignity if you transfer them in an ambulance to another hospital are you? You're not

respecting their privacy, their dignity, I think you could make a valid question even whether he wanted to go or didn't want to go, there was no problem about his relatives getting to either hospital... (U690)

Ursula asked senior nursing management for support:

We kind of went through our lines of authority to try and not have to transfer the patient. We were told that we had to transfer the patient. And then of course he was transferred to the other hospital but was only there for a couple of hours and died, which was very sad. (U654)

Ursula commented that the incident made nurses feel "awful" and "upset". She made some interesting remarks when asked how she dealt with her disappointment at the lack of support she received and the fact that the patient was transferred:

Well, you learn from it (laughter). I think it is one of the best ways to actually see a positive side from a situation like that is that you actually learn from it. You learn which of your colleagues will support you, which of your colleagues has any moral (laughter) backbone and who don't, you learn who believes in what the doctors say more than their own value judgements, you find out which medical staff will do anything, I think, at considerable cost to the patient. I mean, the man was barely conscious when we transferred him. And then to go in an ambulance to [another hospital], to go onto another ward. I mean, it's just... (U739)

Finally, regarding the nurse managers who failed to support her, Ursula commented:

... I would hope that any nurse would... in that situation... come to the same decision. But when we tried to get somebody higher than me to actually say to the doctors, "No this is not right for this patient," they didn't... It's an obvious situation where you feel unsupported... (U751)

It is unclear as to why nurse management failed to support Ursula and other nurses over an issue where nurses thought they could justifiably expect support.

The nurse in charge

The second example of lack of professional support involved Rebecca who, as a junior nurse, felt unsupported by the nurse in charge over an incident where she was asked by doctors to remove a patient's chest drain. Rebecca was inexperienced and

had been a nurse on the ward for only a short period, but thought the patient's clinical signs indicated that removal of the drain might be harmful to him. She informed the nurse in charge who consulted the doctors. Despite Rebecca's concern doctors requested that removal of the drain proceed. Against her better judgement Rebecca removed the drain and unfortunately the patient developed a pneumothorax. Rebecca explained what happened:

I had only been here about a month. It is one of those incidences which has stuck with me throughout. And the gentleman who... had thoracic surgery and was just left with one apical drain in. It had been in for a few days on suction... And I was still quite new in my training but I knew this chap had an air leak in his apical drain and probably if we took it out he would get a pneumothorax. But I knew it was quite a small air leak and that it was not continuous, it was every now and again. I'd been looking after this chap for a few days and I was his named nurse and built up quite a relationship with him... And on the morning, I was doing my drugs and it was the first couple of times I had done a drug round, so I was concentrating on what I was doing. The round was going on around me. And the nurse in charge was saying, "O, yea, that drain can come out today." And I said, "Well are we sure? Because with all these teaching sessions and reading around it and he had still got a small air-leak, and I'm sure that if we take it out he is going to get a pneumothorax." But I didn't want to push my point, it was just that I was led to believe from the teaching that I'd been given and reading around it. And I mean it was like, "O, ok then I'll go back and I'll just check with the doctors if they want to do it." And they said, "Yea, yea, pull it out" and it was quick onto the next person. So, I wasn't happy about taking this drain out. It went against everything that I had read. And, but then I thought, "Well, I've spoken to the [nurse in charge who] is happy for this drain to come out, the doctors are happy for this drain to come out. Who am I to say that it shouldn't?" Even though I wasn't happy, and I took the drain out and the chap did get a pneumothorax. And I said to the [nurse in charge], "Well... was that because it came out too early?" And [the nurse in charge] said, "O yea, it probably was." And... I thought... I took somebody else's opinion just because I thought, "Well [the nurse in charge] should know. The doctors, they should know." And I did something that I didn't believe in but I took somebody else's opinion as better than mine. (R195)

Despite raising her concerns, Rebecca found herself being blamed by other nurses for the removal of the drain. The nurse in charge declined to speak up in her defence and say that she had raised her concerns. She explained:

When I came back the next day and the next person to hand over said, “Well whoever took this drain out should have actually looked at the chart.” And I thought, “Hold on, I did, and I checked that with the [nurse in charge]... and also with the doctors as well and that they’d came and looked at his chest X-ray and what have you.” But [the nurse in charge] never backed me up at all. (R232)

Rebecca clearly felt she was a victim of pressure from the doctors and the nurse in charge. She explained:

There is also an awful lot of pressure on you... The doctors do whiz round and say, “Yea, that can come out.” And I think the person who goes round with the doctors on the round should be pointing these things out. You know, “But did you know, he still has an air-leak.” I mean, the [nurse in charge] actually went back to the doctors and said, “O, Rebecca thinks he still had an air-leak” and they said, “No, the X-ray is fine, take the drain out.” There is an awful lot of pressure to whip things out so that people can get home early. (R285)

While organisation pressures might have played a part, the association between knowledge and power mentioned earlier might also help explain the reaction of doctors to Rebecca’s questioning of the appropriateness of removing the chest drain. Rebecca questioned the decision on clinical grounds. Doctors could have seen her questioning as a challenge to their knowledge and therefore their power and authority.

Rebecca felt there was a general tendency amongst nurses not to support each other and to seek someone to blame (R378). She commented:

I think it also shows a lack of support among nurses. When it did go wrong the person who was handing over the next day was saying, “Well it should never have been taken out in the first place.” And it’s like, “Oh.” There is a very real lack of support among nursing staff. It’s, “O, that person did it.” “It was the student.” “It was a new person.” That sort of thing. (R359)

Rebecca did find a source of support in her mentor, one of the sisters on the ward who helped her learn from the experience. She explained:

I was quite upset about it at the time. And I did get to speak to my mentor which happened to be Winny. We talked things through quite at length and she made me feel a little bit better about what had happened. She looked at it a little bit more objectively... and she said to me, “What

would you do in the future.” [Be] a bit more confidence in what I thought.
(R369)

Rebecca reflected on the incident. She said she felt terribly “guilty”, but also felt she should not take all the blame for what happened to the patient. She said her mentor helped by praising her for the positive things she had done and she felt that the incident was an experience from which she learnt a lot (R378).

Ill-treatment of new nurses

The third example of lack of professional support amongst nurses concerned nurses who were new to the ward. Many nurses thought new nurses on the ward were ill-treated. Rebecca, for example, thought new nurses were poorly supported and mistreated and spoke of how the new nurse was often allocated the ‘difficult patient’ to care for, or the ‘unpopular nurse’ to work with. She commented:

When you’re new you don’t expect, but you anticipate a certain level of support. And... it’s the new members of staff here that carry the can. And you know, ‘O well, that person can look after them’ because you know they are not going to answer back. When people are new here, or not necessarily here, but anywhere, it’s thought that they are new and won’t answer back or they don’t know... you just allocate them that person and they get on with it. You play on the fact that they are naïve or they don’t know the person they are going to be working with, but they’ll soon find out and by that stage somebody else new will have come in. (R550)

Mandy, a newly qualified nurse spoke of being a new nurse on the ward and not getting what she expected or was promised. Mandy had come from a distant part of the country in order to take up her first post as a qualified nurse on the basis of being promised a good preceptorship programme. She commented, “I was expecting we’d get all these courses. Job preceptorship was what I came for. A really good preceptorship programme was advertised and I came for it and it really didn’t come to light” (M41). Lucy, another newly qualified nurse, had a similar story to tell. She also felt unsupported and commented:

... the only reason I accepted this position was because I was promised six months preceptorship. And included in that six months preceptorship was four weeks supernumerary. I had two days supernumerary when I

went up to see cardiac surgery and down to angiogram to see pacemakers being placed in, etc. Otherwise I didn't have any supernumerary time at all. They didn't even give me the chance to get into the ward. I was basically just thrown on patients. My mentor left the ward, so suddenly I was left without a mentor, no one went through any objectives with me. The only reason I took this position was because I was going to have this preceptorship programme which seemed excellent at the time. I was provided with this preceptorship package before I even went for the interview so I could have a look at it and really decide in my mind if I want to go for it or not. And everybody was very positive in the interview. It came and I was just chucked in it with no support at all. (L44)

Gerri also felt unsupported when she began on the ward. She thought time went slowly for the first six months but then appeared to "whiz" by. When asked why this was, Gerri said:

I think because it was hard work and it was hectic on here. Everybody was leaving. And there was no support for us junior people. We were just dumped in at the deep end. And it was all a bit of a nightmare. But after six months you kind of got your feet, got your bearings and it all started to settle out and the staff problems seemed to settle themselves out. (G27)

The ill-treatment of newly qualified nurses was a generally reported phenomenon and did not just apply to a few individuals. It was a very upsetting experience for nurses. Lucy felt unsupported and ill-treated and commented:

... it was general. All the newly qualified nurses and particularly as I said because the sisters were a bit insecure, and the ones they tended to tread on were the newly qualified. And there was quite a few of us and we all felt the same. And we were going home at the end of the day and we were feeling really crap. And we were just like nearly in tears with each other and it was like, "We're not going to cope here any longer." And it was terrible. And as I say everyone was feeling exactly the same. (L335)

Nurses suggested several reasons to explain why new nurses were unsupported and ill-treated. Lucy felt some of the newly appointed sisters were unsure of their role. In fact, as the sisters became more experienced the situation improved (L344). Shortage of nursing staff was another cause, as nurses new to the ward were suddenly running the ward and given responsibilities that they were not ready for. Lucy thought this was probably unsafe. She explained:

... suddenly we were all running the ward without getting any support. A bit of a nightmare, yea. But the thing was, it taught me one thing and that's to be self-directed. And even now I am really self-directed. If there is something I want to achieve, I know I have to achieve it myself. So, it has really learnt me to stand on my own legs really more than anything else. Although, I would say that the practice was probably unsafe. I didn't think it was very safe to be thrown in like that. And I was blamed for things which I shouldn't have been blamed for and put in to take responsibility for things that I shouldn't take responsibility of until I actually had the experience of dealing with things, yea. (L61)

Several reasons might explain this disturbing account of mistreatment and lack of support for nurses new to the ward. Indeed, it may be understood by reference to so-called "dominant culture theory" (Mowforth, 1999a:55). This explains the process whereby members of an oppressed group might assimilate some of the characteristics of the oppressor. Roberts (1983) identified this process in nursing where nurses, as an oppressed group, would attempt to emulate the behaviour of the dominant culture of the oppressor, and in doing so may exercise "horizontal violence" against itself. Hence, the mistreatment and lack of support given to nurses new to the ward may be seen in terms of nurses, practising within a negative hierarchical system, exercising on fellow nurses the practices nursing as an oppressed group feels subjected to.

Nurses new to the ward did not necessary simply accept mistreatment and lack of support. Lucy spoke of learning from the negative experience to be "self-directed" and self-reliant. There was evidence also that nurses new to the ward resisted the mistreatment and lack of support they experienced. They found that if they acted together and spoke up about their concerns they could effect change. One of their motives for doing so was their concern about patient safety and poor professional communications. Lucy explained:

We all expressed, because we were so many newly qualified [nurses], the unsafety of working on the ward and the lack of communication. The co-ordinators would never tell you what is going on and suddenly you would be there and finding yourself in quite a nasty situation and quite an unsafe situation. And we demanded full clinical supervision and the Thoracic Sister or Head Sister at that time came and did some clinical supervision with us, which was great. And that was the only really, really good input that I had at that time, that we could really discuss what should we do with the problem. And we started to stand up for each other and basically having meetings with them, the more senior staff and saying, you know,

“Hang on a minute, this doesn’t work, this and this is happening, this and this is happening” and we were really starting to get on top of things. That really helped, yea. (L108)

Communication problems

Nurses considered good communication important for the effective organisation of patient care and therefore of ethical importance. They spoke of good professional communication, but also referred to times when communication problems caused ethical difficulties. They were concerned that such problems might compromise patient care or in some circumstances might be harmful. Two examples serve as useful illustrations.

The first example concerned the geographical layout of the ward and the way in which nursing care was organised. The ward was ‘L’ shaped in plan with one large ten-bedded bay and a smaller four-bedded bay at the top end. At the opposite end of the ward, the base of the ‘L’ so to speak, were a number of four-bedded bays. A corridor with single rooms connected the two ends. The nurses’ station was situated near the ten-bedded bay and was the managerial, organisational and communication centre of the ward. The ward telephones were situated there and it was the focal point for nurses, doctors and other health care professionals. The patients’ beds were number 1-10 in the ten-bedded bay, 11-14 in the four bedded bay near the nurses’ station and so on down the single rooms along the corridor and around the four bedded bay areas at the far end of the ward. Nurses organised themselves into two teams. If a nurse was allocated patients in beds at the far end of the ward, away from the nurses’ station, he or she may experience a lack of communication that might negatively affect patient care. Gerri spoke of this problem:

I think one problem with this particular ward is the layout. I think, as you’ve got the two geographical teams, from one to eleven and twelve to twenty-three. And if you’re on your own from twelve to twenty-three, you may not see another staff nurse for the whole eight hour shift because you’ve right out of the way, kind of thing. And if you are right up in the last bays... you may never get a look at the nurses’ desk, only to go down and pick up dressings and things like that. So that can be quite isolated. I think that doesn’t help... You are left up there on your own a bit. I don’t think it is the same if you are one to eleven though. That’s completely different because you’ve got the nurses’ station there and you are far

more likely to get communication down there. Doctors are far more likely to tell you things down there, speak to you when they're around. It's just geography, you know. They'll speak to you down there, but they won't come looking for you. So if you're up the other end that doesn't help. (G601)

The second example of communication problems between nurses illustrated how ethical difficulties can arise when processes for passing on information broke down. It was usual for the nurse in charge to go on the morning doctors' ward-round, to note changes in patients' treatment and care, and once the ward-round was completed to inform nurses looking after patients of relevant changes. Lucy recited an incident where the nurse in charge failed to communicate this information and a patient she was caring for might have been harmed. The patient had a chest drain that had been on suction. On the doctors' round a decision had been made to discontinue the suction. The patient's suction was duly discontinued. Lucy was unaware of the change in treatment and when she found the suction had been turned off she restarted it. At the time of the incident Lucy had little experience with caring for patients with chest drains. Her main concern was that she thought failure to communicate changes in patient care and treatment was unsafe for the patient. Lucy appeared to be blamed for an incident that was not entirely her fault. She explained what happened:

I was given quite a few patients to care for, and then the nurse in charge had done a doctors' round and she hadn't told me that she had taken a patient off suction. And I was supposed to look after this patient. I hadn't really been told much about drains and suction yet either. So all I had was my really very basic college knowledge for drains and everything. Came round to the patient and asked the patient why the drain had been taken off suction and he said, "O, I just went down for an X-ray, so they took it off for that." So I thought, "God, I'd better get him back on suction." I put him back on suction, which could have quite a serious consequence. And I got blamed for it. Although I shouldn't really have been blamed for it because I hadn't been handed over anything that happened all throughout the day, which was also very unsafe. So I would go around, and was looking after these patients and there could have been serious changes on the ward-round which I wasn't aware of. That was very unsafe. There were quite a few days that were very unsafe. (L72)

BEING SHORT-STAFFED AND HAVING HEAVY WORKLOADS

The ward environment was one where nurses were faced with being short-staffed and having heavy workloads. Nurses felt this situation adversely affected patient care and was therefore of ethical concern. As we have seen, inexperienced nurses who were new to the ward felt they were, to use Lucy's (L44) words, "thrown on patients" because the ward was short-staffed. Four aspects with ethical relevance could be identified. First, nurses thought being short-staffed and having heavy workloads presented them with an ethical dilemma as they felt whatever choice they made patients might suffer. Secondly, nurses were concerned at the lowering of standards of care and difficulties of priority setting. Thirdly, nurses' workloads were increased because they assumed a pivotal position in providing patient care and undertook the responsibilities of other health care professionals when they were unavailable. Finally, nurses spoke of the stress this situation caused them and the subsequent lowering of morale they experienced.

An ethical dilemma

The first ethical problem faced by nurses when confronted with staff shortage and a heavy workload was deciding how to respond to the situation. Should they try to carry on or should they refuse to accept more patients and suggest beds be closed? This presented nurses with an ethical dilemma, for either way patients might suffer.

One of the main ethical problems nurses faced was whether or not to agree to accept patients transferred from the High Dependency Unit. This was a difficult choice because the implications of refusing to accept patients meant that the normal cycle of care for surgical patients was interrupted. The usual experience of a patient having surgery was to be admitted to the ward in order to be prepared before being taken to theatre. Following surgery the patient would be taken to the Intensive Care Unit and would usually remain there for a short time until extubated and breathing normally. The patient would then be transferred to the High Dependency Unit where he or she would remain until clinically stable enough for transfer back to the ward. The whole surgical cycle depended on the different specialist areas being able to accept patients and pass them on to the next area of care. If one area of care was unable to accept

patients then the whole surgical programme was threatened and patients' surgery may have to be cancelled. Nurses on the ward therefore experienced much institutional and organisational pressure to accept patients and prepare them as quickly as possible for discharge home.

Hilary, as a ward sister, spoke of having to make a choice whether or not to accept patients from the High Dependency Unit. She was fearful of accepting patients when the ward was short-staffed and nurses were busy as it might compromise patient safety. Hilary spoke at length on this issue:

... do you take patients from a high dependency area onto your ward knowing that your staffing isn't adequate?... I think it is an ethical problem if it affects the safety of the patient. And I think that is a major thing at the moment. At the present time the staffing is appalling... and quite often I do feel that it isn't safe. But because of the pressure on moving patients through and there is also an ethical problem in that we have to operate on people within a certain length of time. They shouldn't wait more than nine months to a year on the waiting list and we are cancelling patients all the time. And there is this pressure to get the work through. But on the other hand if the patients aren't going to be safely cared for, you know, where do you draw the line? Do I stand up and say, "I refuse to take this patient from HDU because the staffing levels are unsafe? We have tried everything to get staff in. I cannot get any staff in. I do not feel I can safely run twenty-three beds." Or do we take the patients so that patients aren't cancelled and just hope nothing happens? And that is something that happens virtually on a daily basis now. (H77)

Hilary explained in detail her concerns for patient safety and the maintenance of quality nursing care if patients were transferred from the High Dependency Unit when there was a shortage of nurses on the ward:

If I feel the patient would need more care than one qualified nurse would be able to achieve when they are looking after say, twelve other patients. Whether the patient would be turned if the patient needed turning. If they had a tracheostomy, would there be a nurse available in that area to keep an eye on them? What would happen if their trachy blocked off? Would there be someone there that would see that immediately? Those kind of issues. Or even lesser things, which seem small but to the patient himself or herself they are great things. Like, have their TED stockings been changed for three days? Have they had their dressing done today? Have they had a shower? Does anyone know their bowels haven't been open for ten days since their surgery? Those things that I sometimes think that people who aren't in nursing don't really think about. That if you are the

patient sitting there, very uncomfortable, can't move, do things for yourself, nurses are running around, they're very important things. But none of us like to close beds. We don't close beds. But sometimes I think we've been very lucky that nothing has happened. (H100)

Hilary continued and explained the ethical dilemma she faced as a result of the shortage of nurses. If she refused to admit patients, patient surgery would be cancelled, on the other hand, if she admitted patients their safety may be compromised. Hilary commented:

... there is two sides to the coin. Do you refuse or do you say you can't take so many sick patients because it is not safe or... you feel they won't get adequate care. But if you do that, the other side of the coin is someone will have their operation cancelled. And, I mean, that's an ethical problem as well, should you cancel patients? Or looking at it another way, you know, are we saying that we should operate on more patients than we can manage? Now are the contracts too large? This Trust is saying that we can operate on 'x' number of patients, but can we? Have we got the facilities? Or is someone being a bit over ambitious because it is all related to money? You know, the more patients we do, the more money comes in. (H153)

Hilary's questioning as to whether the demand for high throughput of patients was linked to financial considerations and targets set by the Trust suggest that wider financial and political factors had a bearing on ethical problems experienced by nurses on the ward.

Standards of care and priority setting

As a consequence of staff shortage and heavy workloads, nurses faced ethical difficulties associated with maintaining standards of care and priority setting. Winny, one of the ward sisters, spoke of the difficulties of trying to maintain standards of care when there was a shortage of nursing staff. She spoke of the need for nurses to prioritise and the ethical difficulties in doing so, particularly for new and inexperienced nurses. Winny commented:

You come onto the ward and you are extremely short-staffed. At the end of the day you are providing a service and you want to give the best service and standard of service that you can possibly give. How do you do that when you are one or two nurses down? That's difficult. You have got

to try to deal with it the best you can. Trying to prioritise, looking at what are the priorities, this is the situation this morning, we have this number of staff on, this is what is happening on the ward and try to very much prioritise and deal with it. Perhaps junior members of staff would find it quite difficult. They haven't got the experience to use these skills themselves, they are working as hard as they can and it can all become a little bit much at times. (W760)

Winny continued by explaining how nursing care priorities might change as the day developed:

Patients all feel naturally that they are all equally important, which they are, but in a situation like that six patients need their dressings doing and one has to start off somewhere and prioritise. Then your priorities are constantly changing because... you are starting to do your second dressing and you get called to pre-med somebody who is going up to theatre. That then becomes the priority, to get that patient pre-medded and safely up to theatre. So it is quite difficult. (W777)

Nurses felt that on occasions important aspects of care were not dealt with because of higher priorities elsewhere. Tina experienced this in the incident mentioned earlier where doctors failed to prescribe adequate analgesia for a patient in pain. Tina felt nurses failed to deal with the issue because they were very busy and had other immediate priorities. Tina explained:

... at that time the ward was... very busy and in fact I worked an agency bank shift during that time. I remember looking after the gentleman myself on one shift and I think that sort of brought it to a head as well for me. It was very busy. The nurses had in some ways higher priorities during their workload. Ok, this gentleman needed twenty-four hour care but there was also people who perhaps needed to go to theatre and needed pre-med and things like that. So they did have other priorities that were maybe distracting them from the crux of the problem for this man. (T170)

Hilary was also concerned that being short-staffed meant patients did not get the care they required. She thought some nurses felt guilty because they were unable to care for patients in the manner they would have liked. Hilary recalled an incident that illustrated well the difficulties of being short-staffed and busy. The incident involved two patients who were very ill. Both patients had a tracheostomy and an infection that required they be specially nursed. Hilary explained:

I would say fairly recently that some patients may not have had the care that they require. And, I think that the care could have been better if we had been better staffed. And I think that some of the staff feel that they could have done more for certain patients had there been more of them. And I think that some of the staff tend to feel guilty that they haven't cared for the patients well enough. I mean, we have had a recent problem where we had two patients with tracheostomies both in side rooms because they had infections. And we struggled every day to find someone to care for these two patients. Occasionally we couldn't get anyone to special those patients. So [one of] the nurses... on the ward... had to just care for those two patients, which made the other patients probably neglected... And eventually one of the patients arrested and ended up in Intensive Care. I mean, he was found and resuscitated. You could say had there been somebody in his room all the time maybe he would have been resuscitated more quickly. However, he was on telemetry, he was on the monitor and it was noted that he was in difficulties immediately. And the other patient became more unwell and then was eventually transferred back to the HDU, in a controlled manner. So neither of the patients were able to stay with us particularly long. And it also makes the nurses feel, "Well it's a shame" because had we had adequate staffing numbers these two patients, they would be in a bay together. We weren't allowed to close beds so we couldn't put the two infected patients in a four-bedded bay and close two beds and have one nurse in there. They were in side-rooms and that made things more difficult. I think if we'd been fully established we could have looked after those patients very well. As it was they mostly had agency nurses looking after them. And you know, that is difficult. (H119)

Nurses thought that being short-staffed and busy affected nursing care in a number of significant ways. It reduced the nurse's ability to give individualised care and made it more difficult for the nurse to give psychological care. Hilary spoke of the way in which organisational necessities made it difficult for the nurse to give individualised care. She remarked:

... it is a twenty-four hour service and I always tell them it is a twenty-four hour service and we can't do everything in one shift and I don't expect them to do everything in one shift. If a patient doesn't want a wash till four-o'clock in the after noon I'm not going to say, "Well, he must have a wash at eight-o'clock in the morning." We don't do that. It is a twenty-four hour service. However, you have to do certain things, if you have seven admissions in the afternoon, you have to get the great majority of the workload done in the morning because you won't have time to do the paperwork in the afternoon. So, I think small things, you don't mind handing over to the next shift, but you don't really want to hand over seven dressings and five washes when you know that they've got other things to do on their shift. (H187)

Nurses pointed out that being short-staffed and busy meant they had less time to give the psychological care and support required by cardio-thoracic patients. Psychological care and support was an important aspect of nursing care for patients undergoing cardio-thoracic surgery as such surgery was not without risk and patients were invariably anxious. Val pointed out that when patients perceived the ward as busy and the nurses as stressed they tended not to bring their problems to the attention of nurses. Val explained:

You might have five or seven patients to look after and you're just running around, washes, dressings, breaks, 'obs'... The patient sees you're busy and they don't like to ask. Some are demanding but most, the majority, don't like to ask. They can see you're busy. You don't necessarily have time to pick up on things, you don't notice, to be honest, I don't think. (V703)

Assuming a pivotal role increased workloads

Regarding relations with other health care professionals such as, for example, the rehabilitation team, dieticians, and physiotherapists, nurses assumed a pivotal role in providing patient care. Other health care professionals, like nurses, were also often short-staffed and had heavy workloads. On occasions they were unable to fulfil their functions on the ward and nurses often undertook some of their activities.

Hilary raised this issue and pointed out that, as a consequence, the workloads of nurses increased, they experienced greater pressure, and were less able to fulfil their responsibilities. Hilary illustrated this by referring to the rehabilitation team whose role was to give psychological care and support to patients being discharged home after surgery. Hilary was concerned that when the rehabilitation team was short-staffed and unavailable, nurses assumed their role and was often unable to give the psychological care and support patients required. She explained:

... this week the rehab team are very short-staffed. They have just put up a sign saying, "Sorry, there won't be any cardiac rehabilitation this week. If you think anyone want's to be on the course, leave their name on our phone number." And we've got the [patient rehabilitation information] books that we always use, so of course it is down to us again to do all their rehab. And I actually think that patients have gone home with the book, it's all in the book, but they haven't had the chance to sit down and

ask questions. (H668)

Hilary's concern was that standards of patient care suffered. She continued by pointing out that nurses felt guilty when unable to take on the role of other professionals. Hilary pointed out:

... the nurses on the ward can't... put up a sign and say, "Sorry, there is not enough of us and please leave your name on this number if you want nursing care." (laughter) And the physios say, "We're short today, so we won't be able to do the stairs with anybody." And the dieticians say, "Well, I can't come up at all today because I'm at a meeting and I'm short." So, again I think sometimes the nurses end up taking on all the different roles or feeling guilty because they haven't... been able to, they've just managed to do their normal job. (H683)

Stress and low morale

Nurses spoke of their stress and low morale as a result of being short-staffed and having a heavy workload. Mackay (1989:65) found that nurses identified staff shortages and their effects as the single biggest cause of stress. Nurses in this study were particularly concerned that standards of patient care might be compromised as a result. Val, for example, commented that in order to tackle high workloads there was a tendency to take a task-orientated view and not to consider the patient. She commented:

Yea, because you feel pressured and stressed before you even start the shift, because you are just thinking that you have got to get this, this and this done. It sounds awful but you don't really think of the patient. Well you do think of the patient but more on a task [basis]. (V703)

Nurses likened their experience of stress as being in a vicious circle. They became stressed in the face of being short-staffed and having a heavy workload, and their stress was further increased because, despite their best efforts, it was difficult to maintain standards of patient care. Sally, referred to this. She felt she had a "duty of care" towards patients and pointed out:

... I find it's stressful if you know that the standard of care that you have given isn't as good as it could be. I think it is the most stressful thing, the most, most stressful thing on [the ward] was when I was short-staffed.

You knew your standards were slipping and you tried your damndest to cope with it... (S533)

The effect on nurses of being short-staffed and busy over a period of time was to lower their morale. Nurses responded to a lowered morale in different ways. Jane spoke on the effect of being short-staffed and of one strategy nurses used in trying to deal with lowered morale:

... just before Christmas morale on the ward was very, very low because we were so short-staffed, a few people went off sick because we had this bad cold going around and all that. So we decided we would... go on a ward night out and all that. It hasn't materialised yet for the simple reason that we haven't got any staff. (laughter) It was supposed to be on this off-duty but we haven't been able to do it. But hopefully on the next one we will do it. But they know we will be going on a ward night out... and they are all looking forward to it. (J475)

Despite Jane's best efforts, being short-staffed and busy not only had a detrimental effect on nurse morale, it also appeared to raise tensions amongst nurses. Mandy, for example, explained how with heavy workloads nurses would notice who was or was not "pulling their weight". She commented, "... some pull their weight more than others. Yea, sometimes you think you are doing it all and probably people think the same about you. It's not nice" (M628). Mandy felt that in difficult situations it was necessary to get on with colleagues and pointed out that the majority of nurses did in fact get on well with each other. This, she felt, was important as it influenced the nature and experience of the nurses' working day. Mandy commented:

I mean, I think on here it is quite alright that we get on well most of the time, the majority of us anyway. But yea, you know you're coming on to, what a day? No staff. But at least you're with somebody who you can laugh with them about it. Or, not somebody who you can't work with and you think, "Oh." You know, because that would be even worse, you know. I think if you didn't get on with who you work with it would be so much worse. (M638)

Despite the fact that in general there existed good working relations between nurses, there were occasions when, as a result of being so busy, nurses got short-tempered with each other. Jane described one situation where the workload of nurses was increased as a result of having decorators on the ward painting the walls. She

explained:

Friday morning we were really busy and they were painting those two rooms down this end. So we had to move, we had four empty beds in the main ward, four male beds. In the four-bedder just opposite the nurse's station there were four men in there. So what I did was got those men into the four beds on the ward and moved the ladies into the four-bedder. And besides doing all this we had ward-rounds and you've got your medicines to do and every other thing, washing patients, giving IVs and everything. And I think with all that we were short-staffed as well. And the patients, although we had six fewer patients... their dependency was quite high. And people got a bit short-tempered with each other. Not intentionally, you know. And you had to just calm the situation down really. And say... we are all stressed but just let's try to work with each other. (J443)

Hilary pointed out that nurse morale would be greatly affected if, despite their best efforts in difficult circumstances, they received a complaint from a patient. She commented:

And if you get complaints I think that really does upset people. And if you get a complaint about nursing care that really makes the morale go down because most of the time you are struggling to achieve the care that you want or you expect yourself to achieve. And then you get a complaint and you think, "O no, we really tried our hardest." And here's this piece of paper and you're ploughing through the notes looking who was on and who documented whether she'd been washed or had a drink or etc, etc, etc. And when you know full well that you feel that the patient had good care or you were short-staffed and couldn't give the care. (H196)

Hilary felt morale need not be low simply because the ward was busy and there was a shortage of nurses. She believed an important factor was the quality and experience of the available nurses. The continual use of agency nurses was not the answer as they were usually unfamiliar with the ward and a great deal of time was needed to familiarise them with it. Hilary explained:

... morale doesn't necessarily have to be low if you are short-staffed... if you've got few good staff on you can achieve just as much as five or six mediocre staff. So if you've got three of you on and you manage to get the workload done or the patients are happy, and... you manage to smile to each other a few times... I don't think people mind being busy... If you've got three of your own staff on and they know the ward and know everything you may achieve just as much as if there are seven of you but they are all agencies. I'm not saying that agencies aren't good, because

some of them are excellent, but I think it's just having a different agency each time or just re-orientating new people everyday, day in and day out, showing them around, trying to explain what to do. It's quite wearing really and I can understand why people do tend to leave. (H208)

Difficulties relating to being short-staffed and heavy workloads were compounded by the perception of some nurses that nurse management offered little support. This perception may to some extent be due to the fact that nurse management was situated at another site with the result that any problem was generally dealt with over the phone. However, nurses felt nurse management offered little help on the ward and simply expected them to cope. Kerry, for example, spoke of an incident where she felt managers were remote, uncaring and expected nurses on the ward to deal with problems. She explained:

I mean, this morning has just been a classic. There is suddenly just one of those times when everyone's gone off sick this week. So this afternoon I'm on a late shift, as I say, Hilary [as the ward sister on duty] has ended up staying. Her husband is at home, not very well, trying to look after the baby, rang Hilary, "Please come home." And instead of that Hilary has got to do a long day. And she's informed the managers and they're, "Well cope with it, you've got to." They are not coming in, they can't do anything about the situation and it just leaves you thinking, they don't care. They could at least come across here and have a look at what's happening. But they are just at the other end of the phone saying, "O well, yes if you stay things will be ok." Well yes they will be but that's not the issue. I don't know, situations like that just leave you thinking, "Well they're not very interested." They just want you to cope and get by, which you will, you always get by somehow, but that's not really the issue. (K480)

Hilary, while she did not refer to the above incident, also referred to the lack of support from nurse managers. She felt nurse management did not really appreciate the difficulties of nurses on the ward. She suspected that management might think that she was simply "moaning" when she raised problems. Hilary explained:

I have been in a management role before, so I do appreciate that in a management role you are busy. I can understand that, but I don't think people higher up in our directorate particularly think of things like that. They don't realise. They just think, "Well, they've got twenty-three beds open and they're short-staffed and they're moaning." They don't think, "There's no physios, no rehab nurses either. There is no ward clerk because he's on holiday." And, "How are they?" You know, "No wonder

they are moaning.” And, “They’re saying they don’t want to take somebody from high dependency unit because they don’t feel it would be safe.” I feel they think that we are being troublemakers, perhaps. I don’t know. Maybe, maybe it’s just me being paranoid. (H689)

It is difficult to explain why nurse management appeared to nurses as unsupportive, particularly as nurse managers were often nurses themselves and would have insight into the experiences of nurses on the ward. The answer may lie in the need to understand the “gendered foundations” of organisations (Witz and Savage, 1992). Davies (1992) discusses the nature of nursing management and hierarchy from the perspective of gender and argues that under the influence of a masculine dominated management ethos there has been a failure in NHS leadership to recognise the importance of nursing as it has been associated with ‘women’s work’. This failure, according to Davies (1995:165), has contributed to the existence of poor nurse management characterised by a style that is reactive in nature and concentrates on ensuring that there were just enough nursing staff to cope. Such a coping style increases isolation, worsens resource levels and leads to managers asking more and more of their staff (Davies, 1992, 1995). It also leads to an increase in stress, low morale, burnout, low self-esteem, in-fighting, and an environment that is less supportive and caring of individual nurses (Davies, 1992:240).

EXPERIENCES OF BLAME AND FEELINGS OF FRUSTRATION

In response to their environment nurses commonly spoke of experiencing blame and feelings of frustration.

A culture of blame

Nurses referred to the issue of blame, such that it would appear that there existed on the ward a culture of blame. The existence of such a culture may be linked to some of the features of the ward environment already identified. The coercive and illegitimate use of professional power, dominant culture theory and the notion of “horizontal violence”, the gendered foundations of organisations, and the existence of a reactive nurse management style may all be contributory factors. Already in this chapter we have seen how Rebecca was blamed for the removal of a patient’s chest drain, and

how Lucy was blamed for recommencing suction on a patient's chest drain. This culture of blame had a number of manifestations. Nurses spoke of a tendency to seek someone to blame when something went wrong, to shift the blame onto others, and in the case of some nurses to blame themselves, often unreasonably. Nurses thought blaming others took place at all hierarchical levels. Two incidents serve as illustrations.

The first involved Kerry who spoke of a drug mistake she had made. She explained that whilst under the pressure of being the only nurse on night duty qualified to administer intravenous drugs she gave a patient a bolus dose of a drug instead of administering the drug by infusion via a burette as prescribed. She informed the doctor who came to see the patient immediately. She also informed nurse management and completed the necessary incident forms. The patient suffered no adverse effects. Nevertheless, Kerry was very upset at her mistake, blamed herself, and described how nurses "... flagellate themselves when they make a mistake like that." Kerry was disciplined and given a written warning by nurse management whom she thought were unsympathetic. Kerry recognised her mistake but felt that the response of management was such that if she made a similar mistake in the future and no harm was done she might choose not to document it or would "think twice" about reporting it. Kerry thought this would be inappropriate, as a climate of being secretive about mistakes would not be in the best interests of patients. She felt nurse management was unsympathetic when things went wrong because they did not want to take the blame themselves. Kerry explained:

I think part of it is that we are so indoctrinated into these incident forms. You know, as soon as something unplanned happens you've got to make sure somebody knows about it. And that's fine, I mean, there is nothing wrong with that. I think the problem lies in how it's then dealt with. I think it is usually more from the managers that aren't shop-floor based, they are the ones that want their area to be perceived as being smooth running, perfect, things don't go wrong here. So they don't particularly want to take the blame when things do go wrong. So I think that is where it probably falls down. Incidents don't always get dealt with as sympathetically as they may otherwise have been... You know, we are not allowed to be human, we are not allowed to make mistakes because that affects how the directorate looks to those outside. (K376)

The second example involved Lucy. As an inexperienced nurse who had only recently joined the ward, Lucy spoke at length of being “picked on” by one of the sisters who sought to pass the blame onto her when the sister gave a patient the wrong medications to take home. Lucy described the incident in detail:

... I hadn't actually passed my drug assessment yet, because I hadn't even started to do drugs yet. I was still looking after all the patients. And one of the patients needed discharging. And obviously as I hadn't passed my drugs, I wasn't going to give the patient their drugs either... I learned the basic drugs on the ward but because I had been picked on quite a few times by this one particular sister, I was very reluctant to say very much or open my mouth really. Anyhow, this patient was going to be discharged and the sister took him out to the dayroom, first shouted at me and said to me that, “You never do a discharge by the bed. Why haven't you got him in the dayroom?” You know, you should have done that, you should have done this. And I felt, no one had ever told me that, that I should have put him in the dayroom. Which is not the fact anyhow, because you want to have the patient nice and quiet around the bed so that he can hear what information you are giving. Anyhow, I sat him down in the dayroom and this patient was a non-insulin dependent diabetic who's now been started on insulin because of his BMs been a bit unstable. And she was giving out the tablets and she was going to show me how to do a discharge. And she was giving out the tablets and she gave both hypoglycaemic tablets as well as giving the patient insulin. And I literally didn't dare say anything because I'd been stepped on so many times that I was thinking that I can't do this anymore. And the patient's relatives suddenly turned around and said, “Well actually he's been on insulin once before and I was sure he didn't take tablets then.” And the sister turned round to me, “Lucy, will you go straight away and sort it out and talk to the doctor about it and see what is happening.” And she said to the patient, literally to the patient that, you know, “O, I'm really sorry about that, we'll get the nurse to sort it out.” She was kind of blaming me for it at the end of the day. And having a go at me after the discharge as well, as if it was my fault that she had given the wrong drug to the patient. And it was terrible... I couldn't believe it. And I thought, “I am going to stand up for myself.” So I stood up to the nurse afterwards and I said, you know, “I think we need to have a talk in private.” And I confronted her and said that I thought she had been unfair. And I thought a few little things that had happened in the day that seemed to be suddenly my fault... she had actually taken the blame out on me and given me a go for it. I thought maybe she could be a bit more positive towards me as well, because I was really struggling getting along at that stage. And she just turned around and looked at me and she said, “Lucy, tough. You're a qualified nurse, so grow up.” She turned around on her heels and that's it. I was just like, “This is it, I'm leaving.” Yea. (L291)

Lucy's example illustrates how a junior nurse thought blame was passed down from a senior nurse, and how a new and inexperienced nurse who by her own admission was "struggling to get along" felt unsupported. In fact, Lucy felt she had been "picked on" and "stepped on" to the extent where she was reluctant to speak up, even when she believed she was right. Sadly, when Lucy did buck up the courage to confront the sister in order to discuss how she felt, she was treated in a dismissive and disrespectful way. Incidentally, Lucy did not leave and became a popular and much respected nurse on the ward.

The frustration of nursing

Nurses frequently spoke of feeling frustrated in response to the ward environment, particularly when environmental constraints impeded their efforts to provide ethical care, or when they thought the decisions of others were not in the best interests of patients. They spoke of numerous circumstances that caused their frustration.

Hilary, for example, spoke a lot of her frustrations regarding organisational factors that inhibited her efforts to ensure good patient care. In particular she referred to her concern that patients were not getting the benefit of effective pre-medication. Hilary thought patients were often taken to theatre before their pre-medication had time to work. She felt there were a number of organisational reasons for this, such as doctors failing to prescribe the pre-medication the night before, lack of nursing staff and the use of agency staff. Hilary explained:

... the anaesthetist won't come round and see the patients the night before the operation because they say the list is out too late. So they come at half past seven in the morning when you're in hand-over, leaving one qualified nurse and an 'A' grade on the ward. They write up a pre-med then and say, "Give it." They can't give it because there is only one qualified nurse and you need two to check a CD drug. So we all come out from hand-over, there are two ward-rounds and two drug rounds to do, that's four qualified and three people to take to theatre. You know, health care assistants can't take people to theatre. So really you need about five qualified nurses and you've only got three. And they want you to give a pre-med. And those are the things which are really frustrating. And you think well if the anaesthetist came round the night before, we could have given that pre-med early in the morning. The patient would be comfortable. The patients all go up to theatre wide-awake. Those things

are frustrating on top of having not enough staff and lots of agencies.
(H549)

It was not only major organisational factors and power relations that contributed to nurses' frustration, but also small factors of an organisational nature. Sometimes the small things became ethically significant. Hilary illustrated this point well. She felt nurses did not mind being busy but they found it difficult when they were hampered by numerous small organisational difficulties, what she called "little frustrations". Hilary explained:

I mean, none of us mind being busy, it's just if you can't achieve what you want to achieve and there is all these little frustrations in the day. You want a set of notes and the notes are missing. You want to put up a drip and there are no giving-sets because the top-up hasn't been completed properly or we are out of stock in the stores... You go and get a temperature chart and they've run out because somebody hasn't ordered any. It's not just the patient. It's all sorts of little frustrations. Or the bed-manager has decided to bring in some patients to be re-angioed, and they arrive at nine-o'clock in the morning and you haven't got any beds and the pressure is on to take people from HDU. And then you've got to admit them and send them down for angio, on top of your workload. Or you've got people that the doctors just say, "Come into the dayroom at ten-o'clock from home and we'll look at your wound." And then the nurses who are working at that time have to find somewhere to put the patient because there is no area where you could put them. And they end up doing the dressing. You know, they are just little things as well as the workload. But... when you are continually short-staffed; yesterday I was the only nurse that wasn't a student or an agency nurse on duty. And that is quite frustrating because every time you get an agency nurse they don't know the area, they don't understand the documentation, they may not document anything, you may not know, if you are the only qualified nurse that is permanent, you may not know if they haven't documented anything. They may have given bad care. There may be a complaint in three months time. What can you do? And that's frustrating. (H212)

Hilary elaborated further:

... the things I find difficult, one the staffing and two, the frustration. It seems most of the time you can never get a simple job done. There is always a problem. If you want a certain item from supplies, you can't get it because you have to get an order form signed by a senior person who is never on this site to do it as you're not the budget signatory. And then it takes days to come and then by the time it comes, you don't need it. You know, the probe covers have run out for the electronic thermometers and you can't get those and you ordered them two weeks ago and they haven't

come. Those are the things that I find frustrating. (H537)

The frustration experienced by nurses may be linked to the notions of moral distress and outrage identified by Wilkinson (1987). Moral distress refers to the experience of nurses when their ethical decision-making was limited by environmental constraints and moral outrage occurs when nurses felt the decisions of others, particularly doctors, were morally wrong. Nurse frustration may also be explained by reference to existential theory, particularly the notion of “bad faith” (Sartre, 1948). There were occasions when nurse frustration was linked to the coercive use of professional power. Sometimes nurses found it difficult to resist such pressure and complied with a form of treatment or activity they did not agree with. In such circumstances it may be said that nurses acted in bad faith, which is characterised by the denial of the capacity for personal choice and the responsibilities associated with such freedom, coupled with a tendency to act in accordance with the expectations of others.

CHAPTER SUMMARY AND CONCLUSION

In summary, this chapter sets the scene and explores the nurses’ perceptions of the unethical ward environment. Though nurses were sensitive to the ethics of their practice and able to identify ethical events and issues they experienced, there was some evidence to suggest their sensitivity was constrained by environmental factors. Several factors were identified as constituting the unethical environment. Such factors were divergent in nature and ranged, for example, from the nature of professional relations, to the geographical layout of the ward, from being short-staffed, having heavy workloads, and the use of agency staff, to small organisational factors relating to the maintenance of ward stock.

Professional relations were a major source of ethical difficulties, as they did not always function in the best interests of patients. Nurses felt doctors sometimes made decisions that were not in the best interests of patients and used professional power coercively in an attempt to ensure nurse compliance. As a result nurses often felt “trapped in the middle” between the doctor and the patient. Prescribing medications, differences over wound care, and the reluctance or failure of doctors to refer patients to other specialists were all areas of ethical concern. Nurses also thought

communications with doctors were in some respects poor and did not serve the best interests of patients. The nature of ward-rounds served as an illustrative example. Nurses viewed professional relations with doctors as a matter of “them and us” rather than as a collaborative team working in the best interests of patients.

Professional relations within nursing also presented ethical problems, as they did not always function in the best interests of patients. Nurses spoke of a lack of support at different hierarchical levels, including the ill-treatment of nurses new to the ward. Nurses felt professional communications with each other were hampered by the geographical layout of the ward, and they identified ethical difficulties that occurred when professional communications broke down.

Certain mechanisms of power may explain some of the interactions that took place. The use of ‘fields of knowledge’ to maintain professional power may explain the reluctance of doctors to consult other specialists. Reference to dominant culture theory and the notion of ‘horizontal violence’ may explain the ill-treatment of nurses new to the ward. The concept of ‘gendered organisations’ may explain the reactive management style of nursing and be responsible for a culture characterised by blame and a lack of support amongst nurses.

Being short-staffed and heavy workloads also caused nurses ethical difficulties and presented them with an ethical dilemma regarding their response, particularly over whether or not to accept patients from the High Dependency Unit. It appeared to nurses that whatever choice they made patients might suffer. Nurses’ workloads were further increased because they assumed a pivotal position in providing patient care and assumed some of the responsibilities of other health care professionals when they were unavailable. As a consequence, standards of patient care and priority setting were ethical concerns for nurses. Nurses spoke of the stress this situation caused them and the subsequent low morale they experienced.

In response to their environment nurses often spoke of experiencing blame and feelings of frustration. There appeared to be a general culture of blame on the ward. The response of nurses to the environment was often one of frustration. They were particularly frustrated at difficulties that impeded their attempts to provide good

quality nursing care. The notions of 'moral distress', 'moral outrage', and 'bad faith' may all be helpful in explaining this frustration.

In conclusion, nurses identified a number of complex factors that influenced the ethics of the ward environment and presented them with ethical difficulties. Such factors were mainly concerned with professional relations and matters of organisation. While nurses may have felt frustrated in their attempts to provide good nursing care, throughout the data there is evidence that nurses practised resistance. They resisted these frustrations and what they saw as illegitimate or unwise decision-making. They made their own decisions and exercised choice. With the patient at the centre of their concerns, nurses constantly struggled to overcome the difficulties they faced, to act in the best interests of patients and to ensure their safety.

This chapter has examined features that contributed to the unethical nature of the ward environment, and informed us of some of the ethical experiences of nurses. Nurses also identified three substantive issues that caused ethical problems. These are examined in the following chapter.

CHAPTER FOUR

THREE SUBSTANTIVE ETHICAL ISSUES

While nurses raised many different ethical events and issues, three substantive issues stood out as commonly causing ethical difficulties. They were the issues of late cancellation of patient surgery, patient discharge and planning, and resuscitation. It is the purpose of this chapter to examine these issues in order to illuminate further the diverse and complex ethical experiences of nurses, and those features of the ward environment that gave rise to them. The chapter consists of three sections examining separately the respective issues. The chapter finishes with a summary and conclusion.

There were two themes common to the three issues examined in this chapter. First, in all three issues the ethical concerns of nurses were patient-centred, and involved a wish to promote the best interests of patients and protect them from harm. Secondly, nurses felt many of the ethical problems they experienced were as a consequence of the way in which cardio-thoracic care was organised and the hierarchical nature of decision-making. Nurses said they often faced ethical problems when they were expected to comply with hierarchically made decisions, for example, by bed-managers and doctors, which they considered contrary to the best interests of patients.

LATE CANCELLATION OF PATIENT SURGERY

Many nurses raised the issue of late cancellation of patient surgery and the ethical problems it caused. Patients often had their surgery cancelled at the last moment. Commonly, the patient had been prepared for surgery and was waiting to be taken to theatre. On occasions patients had even been pre-medicated. Sometimes the same patient would have surgery cancelled on more than one occasion. Nurses considered this practice unethical because it was harmful and distressing to patients. Nurses also thought the late cancellation of patient surgery was damaging to their relationship with patients and involved them in deceiving patients. In examining this issue we will

consider, nurses' perceptions as to the cause of the ethical issue, its ethical nature, and finally the response of nurses.

Cause of the ethical issue

Nurses thought the “conveyer belt” (S412) organisation of cardio-thoracic surgery and lack of resources were two principle reasons for the late cancellation of patient. Nurses felt that while some cancellation of surgery was unavoidable and unpredictable, much resulted from a system of organising cardio-thoracic surgery that did not always function in the best interests of patients. Furthermore, it was a system over which they had little say or control. Mandy, for example, referred to the system that continued to admit patients when some patients on the ward were waiting for their surgery to be rescheduled after having it cancelled. This she found “annoying” and wondered why the backlog was not cleared first (M349).

The fact that patients are processed ever more rapidly to increase the efficiency of the use of hospital beds has been recognised (Fox, 1992). The role of wider political decisions in the creation of ethical problems was suggested Lucy. She felt the reason patients continued to be admitted was political. Lucy thought the late cancellation of surgery was commonplace because patients were brought into hospital in order to manipulate waiting list statistics. She explained:

I think it is very political... I think sometimes the surgeons or the consultants already know that they are going to cancel these patients and they still bring them in, because it is all down to waiting lists. And the way the system works is the Government wants the waiting lists down, we still haven't got any more staff, we still haven't got any more theatres. So how are we getting the waiting list down? Well, by inviting the patients in for surgery and cancelling them and send them home again. The surgeon can now present a piece of paper and say, “Hang on a minute, the waiting list is going down. I've had this many more patients in this year than I did last year but I have had to do cancellations.” And it looks different on paper. It is very political... (L484)

Apart from the organisation of cardio-thoracic surgery, nurses also identified the lack of resources as a clear cause. Pat, for example, referred to the shortage of beds in the Intensive Care Unit (P251). Following cardio-thoracic surgery all patients were taken

to the Intensive Care Unit from theatre for the immediate postoperative period. If Intensive Care Unit beds were unavailable then the surgery was cancelled. The availability of such beds was sometimes not known until the last moment. As a consequence a patient who was prepared for surgery may at the last moment be told that it was cancelled.

Nurses felt that late cancellation of patient surgery was an issue they had little ultimate control over. It showed that ethical difficulties faced by nurses often arose as a result of decisions made by others in a hierarchical process in which they had little say. Yvonne raised this point. When asked to what extent problems faced by nurses were caused by the decisions of others she replied, “Hundreds, hundreds on a daily basis. You know, patients being cancelled. And 99% of the time it is the nurse that bears the brunt of the patient being cancelled. It’s the nurse that has the aggressive family on the phone” (Y255). Ursula believed it was a situation that was out of the hands of nurses for two reasons. First, because there may be a lack of resources in terms of available beds, and secondly because consultants and bed-managers were the main decisions-makers with respect to patient admissions and surgery lists. Ursula explained:

There’s always I think problems surrounding the fact that if you have a patient who’s as it were, in the system, like in a way this decision might have been taken out of our hands, but patients that are in the system always kind of get preference. And so perhaps patients might have been cancelled because there were patients in the system that perhaps needed to come up from the HDU and things like that... [patients] might have needed their operations but didn’t have them because the beds were taken by patients that were in the system... I don’t know in a way that’s an ethical decision on nurses’ part because it is kind of taken away by people like bed-managers and the consultants who decide which patients come in and which patients don’t. (U149)

Ethical nature of the issue

Nurses thought the late cancellation of patient surgery was an ethical issue primarily because they considered it harmful and distressing to patients. They also thought it harmful to their relationship with patients as they felt it involved them in deceiving patients.

Harmful and distressing to patients

One example illustrates well the harm late cancellation of surgery can cause. Quincy spoke of an incident that had fatal consequences for the patient and greatly upset the nursing staff. It involved a female patient who had her surgery cancelled three times. She died the night of the third cancellation. The patient's place on the surgical list was given to another patient whose family had "created a stink". Quincy felt this was unjust and also believed the patient was in greater clinical need of surgery. He explained:

... we had a young woman who had had surgery in the past. She was waiting for surgery again. She had, like it was cancelled three times. The third time she was cancelled she had actually been pre-medded. And the reason she was cancelled was that there was only one bed in ITU. And... there was another family, [whose relative]... was first on the list as well, and they created a stink and so he actually got done and she actually had an arrest and died that night. And it was the doctors' decision but because they put pressure on, this guy had only been cancelled once, she had been cancelled three times. And that... really upset me... (Q59)

Quincy continued by emphasising that nurses had cared for the patient over a long period of time and knew her well and were greatly upset by what happened:

It caused a lot of upset on the ward because it was a patient who had been with us long-term... she had been with us basically, on and off for this six month period. So that was quite difficult for us. The waiting lists that exist and the cancellations is one of the things that I find is most difficult to deal with at work. You know, people being cancelled all the time. What would I say about it? The whole case was just a total muck-up. (Q97)

The reaction of patients when told their surgery had been cancelled varied, and included acceptance, extreme disappointment, and in some cases, violent outbursts. Quincy spoke of one occasion when the response of a group of patients was organised and determined. Having experienced the late cancellation of their surgery, six or seven patients "ganged up" and successfully rebelled. Quincy explained:

We've had rebellions by... patients... when they have been cancelled a few times. There was one time just before Christmas, when all the patients basically created a fuss... what happened was they cancelled all the list admissions and did all the patients that were sitting on the ward...

Because they all actually ganged up together and just caused mayhem.
(Q161)

Nurses were particularly concerned when the reaction of patients was one of anger or violence, not only because of the intrinsic harm of distress, but because of possible physical harm they might cause themselves. Yvonne referred to this concern and commented:

This is major heart and thoracic surgery and unfortunately the thoracic patients are usually last on the list therefore they are more likely to be cancelled and they're the people who have carcinomas or whatever. So it is all the more difficult for them. We have had terrible violent situations from patients who have been cancelled... We have had patients pull doors off... in the bathroom. A lady pulled the door off the hinges in the bathroom and threw it against the wall. An incredible amount of verbal abuse more than anything else. You know, it is very, very difficult to deal with. (Y293)

This particular patient's reaction was such that she may have caused herself physical harm. Yvonne commented, "I think she got some chest pain. She got so uptight. She was just very angry and she had not been given information that she should have been given" (Y311).

Harmful to the nurse/patient relationship

Nurses considered that late cancellation of patient surgery might cause further harm by undermining their professional relations with patients and thereby reducing their capacity to care effectively. They were fearful that patient trust might be lost. Nurses felt this process occurred in two ways. First, nurses usually took the responsibility to inform patients that their surgery had been cancelled and it was towards them that patients vented their disappointment. Nurses felt patients saw them as representatives of the system that had let them down. Nurses found this frustrating because they seemed to be taking the blame for a situation that was not their making. Quincy referred to this situation and commented:

I think nurses just get frustrated because we get backlash from the patients. You know, we are the ones that are in contact with patients all the time. And I know the patients are upset and we get the full brunt of it,

whereas soon as a doctor comes round it is like, you know, they are nice to them and it's like, "O, it doesn't really matter, we'll get it done later." But... they will really have a go at the nursing staff about it... (Q113)

When patients reacted violently to the news that their surgery had been cancelled this presented risks of harm to nurses. Lucy gave an example where a patient hit a nurse in the stomach. One of the nurses on the ward at the time was pregnant. Lucy explained:

And I've seen patients who have been so distressed with it. One patient had been cancelled once before and he literally hit a nurse in the stomach. And he was swearing on the ward, shouting, throwing his things about, demanding to see the doctors, and he was going to sue all the nurses, and he was going to sue everyone, and he was taking it out really badly on the nurses. Obviously, we are the ones who have to give the bad news but it is not our fault either that someone has to be cancelled. I mean, we are more like a middle person running in between. And it's so, so hard. And he was so angry. I don't think he realised himself, you know, that he was taking it out on the wrong people, taking it out on the nurses. And he was saying, "All the nurses on this ward are crap." (L529)

Secondly, nurses were concerned that they may be involved in deceiving patients, either by unwittingly misinforming patients as to the real reason for the cancellation of surgery, or by continuing to prepare patients when they knew the surgery was likely to be cancelled. Normally nurses on the ward were informed of the reasons for cancellation when theatre staff phoned them. They would then pass this information on to patients. Occasionally nurses found it difficult to get an explanation as to why surgery had been cancelled and sometimes reasons given by theatre staff were unconvincing. Sally, for example, felt theatre personnel sometimes fobbed her off and the real reason for late cancellation of surgery was not always given to nurses on the ward. As a consequence when nurses informed patients, they might have been unwittingly involved in deceiving them. Sally was also sceptical as to whether patients really accepted the reasons they were given and questioned whether some patients developed a negative view of the whole system, including the nurses on the ward. She explained:

... I just felt that we were being fobbed off... or that they would phone down from theatres and say, "Mr Suchandsuch is cancelled, feed him" and put the phone down. I had to ring back and say, "You need to come and speak to him in that case, and why isn't it happening?" And sometimes you'd get, "I don't know," or "No ITU beds," or "We have to

do an emergency from angio instead.” But sometimes it was quite difficult to find out exactly why. As I say most people, they were always upset, but some of them did accept... people really need to go to ITU after your surgery... But I don’t know how much of that they really accept or they just feel resentful against the whole system and think it is all useless, you know, “You’re all useless.” (S591)

Sally subsequently nursed in the High Dependency Unit and became more aware of the real reasons for cancellation of surgery. She pointed out that when the ward was informed that “beds were full” or “people are ill”, this was not always true. The real situation might be that there was a bed available but a shortage of nurses. Sally concluded that nurses on the ward were not always given the true reason for cancellation of patient surgery and that she had been unintentionally deceiving patients. She was unhappy at this because she thought it was important to honestly inform patients why their surgery had been cancelled, and felt it was important that patients were able to trust nurses.

Nurses were also concerned that they were deceiving patients by continuing to prepare them for theatre when they were aware the patient’s surgery was likely to be cancelled. Nurses knew, for example, that patients were likely to have their surgery cancelled if they were placed last on a long theatre list. Knowing this, when preparing the patient for surgery nurses felt they were taking part in raising false hopes and may be deceiving the patient. Rebecca explained this well:

... I feel that you are building them up for something that isn’t going to happen... I’ve got a very good idea that what I’m saying is not actually going to go ahead. It is almost a lie and pretence because I’m ninety-nine percent sure that this person is not going to go to theatre today and yet I’m getting them so worked up. I’m preparing them mentally and physically and it feels like you are lying sometimes. But then it is not my decision to say, “Well actually I don’t think you are going to go to theatre tomorrow so I won’t bother to do any of this until we know.” And then chances are at the last minute they could actually go. So you have to go ahead with it but it is just that nine times out of ten, and I’m usually right, people don’t go to theatre. (R80)

Rebecca felt it was important to maintain patient trust but late cancellation of surgery made it difficult to do so. In fact, she felt in some ways she was betraying patient trust. Rebecca explained:

They are probably not going to believe anything I say again... a disbelief in [me], "O, she probably knew that all along." Or, "Why should I believe her this time?" Not specifically against me but against the system. And obviously, we are the people at the front, so it does sometimes seem personal... You'd feel as if you would be leading them on and certainly betray some of their trust in that they, patients do hang on to your every word. And it is, "What's the best thing to do about this?" "How do I go about that?" Practical things, like their property when their wife or relatives phone in and they really trust you. And you feel that it is a break in that trust. (R94&178)

The response of nurses

Nurses responded in various ways to the ethical difficulties they faced as a result of the late cancellation of patient surgery. Their response to this situation may be divided into three, informing and supporting patients, demonstrating empathetic understanding, and warning patients in advance. The primary ethical motive guiding the responses of nurses was concern for the best interests of patients.

Informing and supporting patients

The first response was that of informing and supporting the patient. When patients had their surgery cancelled at the last moment it was a difficult time for them and nurses assumed the responsibility of helping them deal with their reaction and of supporting them. As doctors were usually in theatre and did not come to see patients on the ward until they had finished surgery in the late afternoon or early evening, nurses took on the responsibility of informing patients that their surgery had been cancelled. Though nurses took on this responsibility, most thought it would be best for patients if a doctor informed them that their surgery had been cancelled. As Pat pointed out, "... the patient appreciates the doctor coming down and explaining why it's been cancelled... give them the reason and say when they might have their surgery again. And that is something that we wouldn't know at that time" (P197). In this way the disappointment

and distress felt by patients might be relieved. However, it was rare for doctors to inform patients and this made it more difficult for them. Yvonne explained:

There are obviously reasons for patients being cancelled but it's rare for the doctors to come down and explain it to the patient. All they want is information and they want someone to be able to see them and as nurses we try to do that but it is not enough for us to give information, they want to hear it from the consultant or someone from their team. Just for them not coming down and doing that provide problems in itself because the patient becomes more and more aggressive or dissatisfied or anxious. (Y259)

Rebecca felt it was not the nurse's job to inform patients but, like other nurses, did so in order that patients could end their pre-surgical fast and have something to eat and drink. In preparation for surgery patients were 'nil by mouth' from midnight the day before. Cancellations usually took place in the afternoon. If nurses did not inform patients they would have to suffer the discomfort of not being able to eat or drink until doctors informed them later in the day. Rebecca pointed out:

... although it is not the nurses who should tell the patient that their surgery is cancelled... it is us that actually have to go to tell them because otherwise they will be waiting till the end of the theatre day and they would be nil by mouth for the rest of the whole day. So you feel that you have to go to tell them though you know it is not your job to do that. So, obviously we get the first response, which is always very angry. (R58)

Nurses spoke of the difficulty they had in dealing with the emotional upset of patients when surgery was cancelled particularly as the reaction of some patients was anger and violence. Sally commented:

Basically the patients are very upset and very angry a lot of the time. There'd be anger with the person in front of them and it might be me... I'd explain exactly as far as I know why their operation has been cancelled. The usual excuse was there was no ITU bed or we had to do an emergency in theatre. And some days when I didn't know for sure, I tried always to find out, surgeons weren't always very forthcoming. And explained to the patient and they would rage and shout and yell. I was nearly punched one day; the poor man was so upset. He wanted to punch somebody and he said, "I think I'm going to punch you."... But yea, very upset and quite resentful at times as well. I thought, you know, it was so unfair to them. But I wish they wouldn't get so angry with me. A lot of them do say, "I'm sorry it's not your fault." But they rant and rave about

the health services, and... why aren't there more beds down there? And I say, "If there were a hundred beds there'd be a hundred people in them." I'm just really trying to provide them with as much information as I could. (S568)

Mandy also spoke of the difficulty of supporting patients who were upset at being informed that their surgery had been cancelled. She referred to situations that sometimes occurred where patients had their surgery cancelled after they had been given their pre-medication. As pre-medication induces sleepiness, some patients were surprised to find when they awoke that they had not had their surgery, but were being informed that it had been cancelled. Mandy commented:

... there's been people pre-medded and they're asleep. And, you know, you go in and they think they've been done, and "You've not been done, I'm sorry, you've been cancelled." And it's like "O." It's horrible. You know, but that's just it, they ring down and that's it, we have to tell them. I mean, very often if it happens, they've been cancelled and I say, "Are they going to come down and tell them?" 'Cos we always get it. We always get it in the neck, nurses, yea. (M362)

It was particularly difficult for nurses to inform and support patients if they had had surgery cancelled more than once. Winny referred to this issue and felt one of the best ways of supporting the patient was simply by listening:

... how can you reassure somebody when you have been cancelled for a third time? I think just being there with a patient and just listening to them and trying to be an ear for them, letting their emotions... it is very difficult. It is not something that I have found very easy to deal with. (W330)

It became more difficult for nurses to psychologically prepare patients for surgery after they had previously experienced late cancellation. Rebecca, for example, said:

I think they are very sceptical. They believe it when they see it. And I don't think they prepare themselves as well as perhaps they would have done because they are preparing themselves to be let down as well as preparing themselves for surgery. There is a patient on the ward at the moment who has been with us for about five or six weeks now and he had been cancelled three times. Two of those times he knew that he was going to be on the end of a list if they'd got time, so he was not preparing himself perhaps as well as he should have in that he felt, "Well I'll believe it when I see it." So they are not getting their full psychological

preparation because they are preparing themselves to be let down as well.
(R103)

Empathetic understanding

An important aspect of the response of nurses in supporting patients when their surgery was cancelled was to demonstrate an empathetic concern. By doing this nurses sought to appreciate the experience of patients and the effect on their lives when their surgery was cancelled. Lucy, for example, imagined how patients must feel and explained how nurses disliked having to inform patients. She commented:

Terrible, terrible, the poor patients... I can just imagine... going in for massive heart surgery, shaving, getting ready, relatives are worried, you have been sitting, maybe crying for the last week because you have been so anxious about it, and then being cancelled over and over again. It's horrendous. And it is something every nurse on this ward hates doing and hates going to tell to the patients, breaking that news. It's really not nice.
(L497)

Yvonne also showed empathetic concern in considering how cancellation of a patient's surgery might affect both the patient and the patient's family. She thought nurses had a greater appreciation than doctors of the psycho-social effects of cancelled surgery. She also thought it was important to ensure patients were fully informed. Yvonne explained:

... I think that some doctors have very little understanding of the impact of cancelling someone. For some of our patients they are cancelled once, twice, three times, you know, major heart surgery. I think they have a very poor understanding. Whether the patients are young or whether they are old, they've got a life. It might be planning for Christmas, it might be to take the kids to school next week, it might be an elderly relative who is in respite care. You know, just one cancellation can throw a multitude of problems at the patient at a time when they really don't need it. I think that, apart from obviously not cancelling patients, the biggest thing is just giving them information. It's not always enough if it comes from the nursing staff; they want to hear it from the person who should have done the operation. They want to know why and they want to know when it is going to happen again so that they can plan. (Y271)

Quincy also thought doctors did not appreciate the psycho-social effects cancelled surgery had on patients and felt it was irresponsible to keep putting patients on the

surgical list when there was a backlog on the ward. He also believed it was important to ensure that patients were fully informed and aware that surgery might be cancelled even at the last moment. Quincy commented:

... doctors don't seem to realise what pressure they are putting on patients by cancelling them all the time. It's like, no matter how far in advance the beds are blocked in ITU, you still have to put the patients on the list... Well, that's what I find. And it's like, they always pile people on the list with the false ability that they might get them done, but knowing fine well that they won't. And it is irresponsible to put a lot of patients on the list. You know, it is trying to make the patients aware... I always tell patients that... there is a high likelihood that they could be cancelled and not to get their hopes up until they are actually up in the operating theatre asleep. And even then, you know, it is not always guaranteed. (Q121)

Warning patients in advance

As Quincy has already indicated, nurses responded to the situation of the late cancellation of patient surgery by adopting a policy of warning patients in advance of the possibility. Nurses ensured that both patients and relatives were told on admission to the ward of the possibility that surgery might be cancelled. Lucy, for example, commented:

... say to the patient, "I'm sorry, we might not have any Intensive Care beds. In that case you might be cancelled in the morning. But prepare yourself for surgery, but prepare yourself as well that it can be cancelled."... On admission... we always inform the patient that cancellations can occur and prepare them as much as we possibly can. (L507)

Quincy agreed with Lucy:

I tell them on their admission. I think it is very important that they know that there is a real high chance that it could be cancelled. And it is like, even at the very last minute. I think they need to be kept aware that there is no guarantee until they are actually on the table and being cut open that they are actually going to be operated on. (Q136)

Summary

Many nurses raised the issue of the late cancellation of patient surgery and the ethical problems it caused. They felt that while some cancellation of surgery might be unavoidable and unpredictable, its cause lay in a “conveyer belt” organisation of cardio-thoracic surgery that did not always function in the best interests of patients. Nurses perceived the system to be governed by political demands to reduce waiting lists, yet shackled by lack of resources. Nurses saw themselves as having little control over the cause of late cancellation of patient surgery and felt that the subsequent ethical difficulties they faced resulted from the hierarchical decision-making of others.

Nurses considered the practice unethical for two principle reasons. First, it was contrary to the best interests of patients and was harmful and distressing to them. Secondly, nurses feared it damaged their professional relationship with patients and eroded the trust patients had in them. They were concerned that patients might identify nurses as part of a system that had failed them and which could not be trusted. Nurses were also concerned that they might have been involved in unwittingly deceiving patients regarding the reasons for cancellation of surgery and that they might be seen as raising false hopes and deceiving patients when they continued to prepare patients but were aware that cancellation was likely.

The response of nurses was governed by concern for the best interests of patients. They believed the responsibility for informing patients that their surgery was cancelled lay with doctors, as they were more able to fully inform patients and answer questions. Despite this, nurses took on this responsibility in order that patients could end their pre-surgical fast and were relieved of the discomfort of being “nil by mouth”. Nurses found it ethically difficult to deal with the reaction of patients, which varied from emotional upset to violent outbursts. In particular, nurses referred to their frustration that patients sometimes vented their anger towards them. Nurses were concerned that once patients had had their surgery cancelled it was difficult to psychologically prepare them the next time. Nurses also strove to empathetically appreciate the experience of patients whose surgery was cancelled and what psycho-social effects it had on their

lives. In this respect they felt doctors did not appreciate the adverse psycho-social effects cancelled surgery had on patients. Finally, nurses thought it important to pursue a policy of informing patients and relatives on admission to the ward that surgery might be cancelled.

PATIENT DISCHARGE AND PLANNING

Many nurses spoke of the ethical difficulties they faced with respect to patient discharge and planning. They thought certain decisions were not in the best interests of patients and that they were occasionally discharged from hospital prematurely and as a consequence might suffer harm. In examining this issue we will consider, nurses' perceptions as to the cause, its ethical nature, and finally the response of nurses.

Cause of the ethical issue

Nurses thought ethical difficulties associated with patient discharge and planning arose, like those associated with late cancellation of patient surgery, as a consequence of the way in which cardio-thoracic surgery was organised. Nurses explained that there existed a continuous need on the ward to vacate beds in order to make them available for patients on the surgical waiting list. As a result there was pressure to discharge patients home quickly, and nurses felt patients were sometimes discharged prematurely. Val referred to this issue. She thought patients were sometimes discharged home before they were ready, and spoke of the speed with which they were now prepared for discharge following surgery. Val commented:

... early discharge I think is... a problem, when the patients aren't ready to go home. It is very quick after cardiac surgery, five days... I mean when I first started it would maybe be a week, seven days, but it is now cut down to five days. I discharged a chap on Saturday after four days, cardiac surgery, that is very, very quick. I mean, some of these people are not ready to go home. (V182)

As with late cancellation of patient surgery, nurses felt the ethical problems they faced relating to patient discharge and planning occurred as a result of the hierarchical decision-making of others, in this case, primarily of doctors. As a consequence the views of doctors and nurses sometimes clashed. Sally, for example, felt that "conveyer

belt” surgery resulted in patients being sent home prematurely and described how she had several “run-ins” with doctors on the question of patient suitability for discharge. She commented:

You know there is lots of hassle about getting patients in, getting them surgery... getting them out, getting them home away, conveyer-belt type thing. And there were occasions, lots and lots of occasions when patients were being asked to go home when they... weren't ready to go. And that their home circumstances weren't going to be supportive enough of them. And that surgeons were suggesting that they just go, that they're fine, "We're not going to do anything more for them, this is a cardio-thoracic ward, out you go." And I've had several run-ins, some I won, some I lost. (S412)

The issue of patient discharge and planning highlighted important professional differences between nurses and doctors. Nurses appeared to see doctors as representative of the system of organising cardio-thoracic surgery that did not always work in the best interests of patients. Sally, for example, felt doctors were influenced in their decisions by the need for beds and the requirements of the waiting list. In fact, Sally was one of a number of nurses who highlighted philosophical and epistemological differences between the two professions. Doctors and nurses appeared to view patients differently and to have different knowledge with respect to them. Sally considered the doctors' assessment of patient readiness for discharge was mainly clinical and physiological whereas in comparison nurses were more concerned with the psycho-social health of patients and what happened to them when they went home. Sally explained:

... it made me think about this big difference between my job and [the doctors] job... to suggest that say an eighty-one year old woman who lived on her own should go home to be on her own. Or there'd be complicated discharge arrangement for Tuesday involving lots of carers coming in and they want them out on the Monday because they need the bed. And it means that you get labelled with, "You're too soft." And I tried to explain to one of the registrars the difference between his job and my job. I need to worry. My duty extends beyond the doors of this place as what happens to people when they go home, and what sort of support they have there, and they didn't seem to worry about that. They just want in out, in out. (S412)

Sally thought some doctors were sympathetic to the discharge planning of nurses but others viewed patients in a mechanical way rather like a car going into a garage. She was concerned that patients suffered when their discharge was not properly planned. Sally felt the discharge of patients was sometimes rushed and was concerned that nurses tended to be blamed when things went wrong. She explained:

Some [doctors] are sympathetic to your discharge planning and what they will need and others aren't. And it is basically like a car going into a garage, "We've done the plugs and the points and reconnected this, that and the other. It looks fine now, drive it away." It might crash halfway down the road but they didn't seem to think about that or think that it doesn't matter, that they've done their bit and that I'm here, as a nurse to tidy up later on and get the patients out so they can get the next one in. I'm not saying they don't care but problems have arisen when people have come back after six weeks with an outpatients appointment and they've been a mess. Or, they haven't been properly discharged which is then blamed on us. What happens is that somebody comes round at eight o'clock in the morning and says, "You can go home today." They phone the relatives who arrive at ten. So, you go through tablets, you go through what to do, what not to do, and they don't listen because all they want to do is get out of the door. And then when they come back in six weeks time, when they haven't taken their aspirin every day... [doctors] say, "O, it's your fault, you didn't explain properly." (S433)

Sally believed it was essential that nurses had knowledge of the psycho-social circumstances of patients in order to safely plan a patient's discharge home. She thought that having such knowledge represented a major difference between nurses and doctors. Sally felt doctors communicated much less with patients and generally knew little of their psycho-social circumstances. She commented:

... I mean their longest contact with the patients is when they are unconscious in theatre. They see them briefly on the round in the morning. They don't know anything about their home circumstances. They don't talk to them particularly. They don't seem to appreciate that there is no point going through all this surgery if they then send them out to drift, to botch things up and not to comply with their medication or the advice they have been given. (S462)

Ethical nature of the issue

Patient discharge and planning was an ethical issue for nurses because they thought its organisation was sometimes contrary to the best interests of patients and indeed might

be harmful. Several nurses spoke of their concern and gave illustrative examples. Sally recalled an incident that involved an elderly man who agreed reluctantly to be discharged to a convalescence home. He did not wish to go and shortly after arrival absconded. Sally explained:

An elderly patient who had quite a long stay on [the ward] and an elderly wife at home. And wasn't really fit to go home for say three or four days after they wanted to discharge him. But they wanted him out. He wanted to stay. He liked the ward and trusted people. He was quite happy there. They wanted him out because they wanted the bed and they arranged convalescence... [at a convalescence home] for him. And he went down there in a taxi to [the convalescence home], went in through the door and about an hour later ran away. He said, "I didn't like this, I didn't want to be here, I never did want to be here." Came out, wandered about and eventually got a taxi, which cost him an absolute fortune to get home. And he was home that evening with his wife. Nobody knew where he was. (S476)

Sally continued by saying she felt nurses were pressurised by doctors to discharge the patient because his bed was needed for another patient. Nurses in turn put pressure on the patient who agreed to go to the convalescence home. In effect nurses felt pressurised into taking action they thought wrong and contrary to the best interests of the patient. Sally explained:

There was pressure put on the nursing staff for the bed. He was blocking the bed... We knew he couldn't go home. So we thought the next best step would be convalescence. He wasn't too happy about that either, but we showed him the booklets and he was more or less pressurised to go, which was wrong, very wrong as we found out when they phoned up and said that he had absconded. (S492)

Sally reflected on the incident. Her comments demonstrated not only her knowledge of the patient's psycho-social circumstances but also her concern for the patient's welfare. She pointed out:

His wife was about eighty-nine. They both went out to do the shopping every day. He cooked all the meals and I know he fully intended to go home and thought he could do all that, and he wasn't fit to do it. He was quite adamant that he'd just pick up where he'd left off. It wasn't that he really listened, "You're going to be really tired, you need to rest." ... I don't know how he coped after he went home that night. He didn't come

back in. But then he may have been admitted to another hospital. I don't know. (S513)

Val also thought patients were sometimes discharged from the ward prematurely. She felt that while a patient might be clinically and medically prepared for discharge, without psycho-social preparation early discharge home might be harmful. Val gave an interesting example to illustrate her point. It concerned a man who despite having few clinical symptoms was admitted for cardiac tests. He was shocked to find that he needed cardiac surgery. Following surgery, when doctors said he could be discharged, Val thought he was not psychologically ready. She explained:

... he was not expecting to have cardiac surgery at all. He had very few symptoms before he had his angiogram and then presented with very occluded coronary arteries and had to have a triple bypass surgery. So he had to stay in, he couldn't go home. He was expecting to come in for a day. He was not expecting to have the full works. He was very scared to go home and I don't think the doctors listened to how scared he was about going home. He and his family talked to me about it. I don't think the doctors necessarily listen. He had a lot of family although he was divorced from his wife but she lived near and could do his shopping and washing and stuff like that. But he wasn't ready to go home at all. He thought five days was far too early after open-heart surgery... Well, I understood his worries. I thought physically he was able to go home. He didn't have a wound infection, he didn't have a chest infection, he was up and about, things like that. But I understood the worry because he didn't think he had cardiac disease in the first place. He had a bit of a cough and that was about all he had, the symptoms that he had before he had his surgery. He went for an angiogram and he didn't really understand why he was going for an angiogram and then was not allowed to go home, had to stay, had surgery the week after, triple bypass and then after that he was expected to go home after five days. (V182)

Val felt that to be discharged home only five days after surgery was too soon for the patient. She also felt doctors did not take into account the home circumstances of patients. She continued:

He wasn't prepared. I often think that on a ward-round with doctors that they don't listen to the patient's circumstances at home. They've done their bit. They have done their surgery. Which is fair enough in a way but with elderly patients of which a majority of ours are anyway, 60 to 70 years old anyway, but I don't think a lot of them are ready to go home sometimes. (V216)

Val continued by referring to the inadequacies of the doctor's ward-round where she felt doctors would be concerned for the physical health of patients but would show little concern for the psychological health of patients. She continued:

Not on a brief ward-round, no. When we've got, we used to have thirty-odd patients up here and they'd see a patient for an average of two to three minutes, run through their drug charts, shake their hand and stuff like that and, "Who have you got at home, your wife?" That's about all they ask. I think the nurses are much more involved in the home circumstances and the after-care than the doctors are. (V226)

In order to help this particular patient, Val spoke to the patient's family and involved the cardio-thoracic rehabilitation sisters so that they came and spoke to him.

The response of nurses

With respect to the ethical difficulties they faced, nurses strove to act in what they considered the best interests of patients. While Sally's example cited above suggests nurses sometimes succumbed to institutional and hierarchical pressure, they also resisted such pressure. Winny, for example, insisted that where nurses and doctors differed in their opinion regarding the readiness of patients for discharge, nurses had a responsibility to assess the social circumstances of patients and to ensure that their discharge was appropriately organised before they were allowed home. It was wrong, for example, to send patients home after heart surgery if they lived alone. Winny explained:

I mean for instance on a ward-round they would say, "Home tomorrow." And you would know that there was no realistic way that your patient could go home tomorrow... there is nobody at home... Things have got to be organised before you can actually organise a discharge and they don't always grasp that that's a very real thing for the patient. It's just a matter of, "O, you can go home tomorrow"... As nurses... we assess the social circumstances. We have got to think about who they've got at home if you're sending them home after heart surgery. We are not just going to send them home on their own, alone. (W591)

Winny continued by pointing out that if doctors wanted to discharge a patient home but nurses believed he or she was not psycho-socially ready then:

... you would say it to the medical team that it is not feasible for the patient to go home tomorrow and depending on who it is they may say, the next day or as soon as you can get it organised. But I have been in a situation where the medical staff just, full stop, haven't understood it. They have said that the patient can be discharged tomorrow from a medical point of view and we need the bed for somebody else. That can be quite difficult and sometimes there can be a lack of understanding on their part. (W611)

Winny suggested that in situations where nurses and doctors disagreed, patients would remain in hospital if in the opinion of nurses they were not well enough to be discharged home. Winny illustrated this point by referring to an incident where a doctor declared a patient suitable for discharge despite a wound infection. The doctor felt the district nurse could treat the wound. Winny disagreed. She thought it was inappropriate to discharge the patient because the wound may become a problem. Winny pointed out that in such circumstances it was necessary for the nurse to be democratic and have the personal quality of assertiveness. She explained:

They might say, "I've seen the wound and I am happy with the wound." Then I'd say, "Well I think you need to look at the wound again because... I feel that it has got the potential to become a problem." I think it is... how you actually deal with a situation. I mean if you go in with all guns blazing saying, "I don't agree, this patient..." You have got to be democratic and assertive. (W640)

Nurses thought doctors generally listened to their advice. Nicky thought doctors listened to nurses regarding discharge planning because nurses had knowledge of the home circumstances of patients (N345). Hilary agreed with Nicky. She felt doctors listened to the advice of nurses, particularly if that advice was clinical in nature. Nurses had close contact with patients and were aware of the physical condition of patients. Hilary commented:

... if we feel that the patient isn't ready to go home we say why we think that and give all the reasons. And usually they do listen to us. I don't really think they stand there and say, "This man is going Tuesday, regardless." And I'm saying, "Well his saturation is only ninety on air or eighty-nine on air and he can't even walk to the telephone or the toilet." If I said all that, they would say, "Well we will probably give him a couple of more days then." And usually we like them to do two flights of stairs before they can go home, because if they can manage that they're usually

quite well. I think in that respect they do listen to the nursing staff because they know we see the patients all the time. (H348)

Ursula spoke at length regarding patient discharge and planning. She also thought doctors were prepared to listen and be influenced by the opinion of nurses. Ursula pointed out that nurses adopted a policy of being more proactive, and rather than simply letting doctors decide, nurses assumed a more leading role in discharge planning. Ursula thought nurses needed to have certain personal qualities in order to do this, as some doctors were autocratic. Nurses needed to be strong, confident, and to have clinical credibility in order that their opinions were listened to. A good rapport between nursing and medical teams was also important. Ursula explained:

... we tried to... lead the discharge more. Be a bit more proactive and instead of the doctors saying that the patient is ready on the round, we could say that Mr So-and-so according to us has passed all the criteria and we think he is ready and happy to being discharged on a certain date. And the doctors seem to be sort of quite happy with that. But I think it is a lot to do with confidence and you have to build up a good rapport between teams. I think, being realistic, that cardiac surgeons are particularly difficult... perhaps it is just the way they have been trained but they come out as very perhaps autocratic people. You have to be quite strong to have your opinions listened to and I think you have to be very clinically credible as well. I think then that people will listen to you, but I think that there will always be odd people within the medical profession that won't listen to anybody but I think they are getting fewer and far between. (U253)

Ursula thought nurses also needed to be up to date with current patient discharge practice in other centres. She pointed out that nurses developed a checklist of criteria. She emphasised the need for nurses to have knowledge of the psycho-social health of patients so they could play an important role in the discharge planning process. Nurses also needed to be able to put forward an argument in a knowledgeable and logical way. Ursula continued:

I think you have to make sure that you're not just going with custom and practice. Like everybody's being discharged on this ward on day seven and so they will still be discharged on day seven no matter what you say. When it might just be that the person you're talking to is more up to date, more advanced and perhaps knows what they are talking about a bit more. But I mean we did sort of develop a checklist... We were able to say... this patient has done this, this and this, he's happy, he wants to go home,

he's got the right social circumstances and stuff like that. I think in the end it worked out quite well because we know the patient's circumstances... the environment that he's being discharged home to, how you think he will cope psychologically with the discharge, how he is going to feel about rehab and things like that a lot better. And that if you can present this in a knowledgeable, logical way to medical staff then they are quite happy to listen. They are quite willing to listen. (U281)

Summary

Many nurses spoke of ethical problems relating to patient discharge and planning. They felt such problems resulted from the "conveyer belt" organisation of cardio-thoracic surgery and the need for rapid throughput of patients. As a result nurses faced pressure to discharge patients prematurely. Nurses felt the issue of patient discharge and planning was a source of conflict with doctors, and highlighted some difficulties in their working relationship with them. The issue also highlighted some of the differences between the two professions. Nurses thought doctors tended to be clinically and physically focused in their assessment of the readiness of patients for discharge, while their assessment emphasised concern for the psycho-social health of patients.

Nurses described incidents where they felt pressurised by doctors to discharge patients who they believed were not ready to go home. This they felt was contrary to the best interests of patients and might be harmful. In general, nurses resisted pressure to discharge patients prematurely and insisted that patients were psycho-socially, as well as physically prepared. With their knowledge of the psycho-social status of patients, nurses thought they were ideally placed to organise patient discharge. Nurses organised to be more proactive and, rather than simply allow doctors to decide, took a more leading role. In order to do this it was necessary to have good rapport between the nursing and surgical teams. Additionally, nurses thought it was necessary to have certain personal qualities. They needed to be strong and to have confidence and clinical credibility. They also needed to be assertive and democratic in their discussions with doctors and to put forward their arguments in a knowledgeable and logical way. When they did this doctors were, nurses felt, prepared to listen and take advice.

RESUSCITATION

Many nurses raised the issue of resuscitation and the ethical problems it caused them. These ethical problems had a number of characteristic features. As with the two previous issues discussed in this chapter, nurses felt certain decisions made hierarchically by others were contrary to the best interests and even harmful to patients. They felt they were in some cases institutionally pressurised to comply with decisions they considered contrary to the best interests of patients and thereby contravened their ethical code of practice. Nurses spoke of the degree to which they were profoundly and emotionally affected by some incidents and appeared to experience moral distress and outrage, experiences Wilkinson (1987) found American nurses involved in end of life situations frequently had.

As with the previous issues discussed in this chapter, nurses felt the ethical problems they faced occurred as a result of the hierarchical organisation of cardio-thoracic surgery. With respect to the issue of resuscitation, nurses were dependent on the decision-making of doctors. Nurses were usually first on the scene when a patient had a cardiac arrest and were obliged to instigate resuscitation unless a 'do not attempt resuscitation' (DNAR) order had been properly recorded by the responsible consultant (BMA, 2001). Failure to initiate resuscitation could leave nurses open to criminal charges (Dimond, 2002). Nurses were therefore dependent on this decision and its documentation, yet they felt doctors were reluctant to make resuscitation decisions or to document DNAR orders. Lucy, for example, commented:

... at one stage we had a set of doctors who never wanted to sort out the patients' resus status. Which I thought was one of the worst ethical issues that I've seen on this ward, ever. And I have never seen another ward with an ethical issue like that occurring and occurring and occurring. (L144)

Sometimes nurses faced ethical problems because doctors had not made the resuscitation status of a patient clear. Ursula explained that "... there were a couple of times where... there was ambiguity from the medical staff about whether they expected a patient to be resuscitated or not. And you had to go back to them perhaps more than once to get a definite decision..." (U67). Ursula felt that the difficulty might be caused

by the fact that the consultant was often absent and others were reluctant to make the decision (U67). Some nurses felt doctors considered it a defeat when a patient died, were unwilling to admit it and were therefore reluctant to make DNAR decisions. Instead they made what might be called 'half-way' decisions that were ambiguous and problematic for nurses. Quincy explained:

... our surgeons are very, very loath to put in the notes, 'not for resuscitation'... you'll get things like, "For one DC shock" or, "Not for intubation but for cardiac massage". And to me that's pointless. You either go full one way or you don't. And... they've all had the guidelines; we've been to meetings with them about what they've got to do. There's been things from the cardiac directorate about it and they've all got copies of the 'not for resus' policy and everything. But they still seem to come round, and like, well, "Do this and one DC shock." (Q253)

Nurses raised many examples that illustrated the ethical problems they faced regarding the issue of resuscitation. It is illustrative to consider three. The first involved an incident where, in the absence of DNAR documentation, nurses were faced with the possibility of having to attempt to resuscitate a terminally ill patient. It raised ethical concerns with respect to beneficence, non-maleficence, and patient autonomy. In the second example nurses had to attempt to resuscitate a terminally ill man because doctors would not document their DNAR order. As with the first example, it raised ethical concerns with respect to beneficence, non-maleficence, and patient autonomy. The final example involved nurses faced with the possibility of having to attempt to resuscitate a woman who requested that she not be resuscitated. Doctors declined to respect her wishes and declare her not for resuscitation. Respecting patient autonomy was central to this example.

First example – the possibility of having to attempt to resuscitate a terminally ill patient

Two nurses, Lucy and Gerri, recalled an incident where, in the absence of a DNAR order, they were faced with the possibility of having to attempt to resuscitate a terminally ill woman. Gerri's account of the incident is considered in the chapter on narrative analysis, so I will here concentrate on Lucy's remarks. Lucy recalled this incident in detail:

... she was... [a]... really nice lady... And she was deteriorating... on the ward and she was getting so poorly. And the doctors refused to sort out her resus status... the doctors just didn't want to listen. And I remember one day, it was actually the same day that she later passed away... I was there with her and Gerri was there with me. We were like, the two staff nurses and we also had two students from the college with us who were getting very emotionally involved with the whole situation as well. And we were standing there around this patient's bed and having her on the monitor... her heart rate dropped from about sixty down to fifty to forty, all the way down to about twenty. And it was gradually just going down and her breathing was laboured. And me and Gerri just couldn't do anything. We were just standing there paralysed. We were just in such an ethical dilemma. Were we going to resus this frail little lady? We were actually going to cause more pain than it was worth when she could actually pass away nice and quietly. She was comfortable when it come to pain and everything, while we were going to go in there and start resusing. And the half a minute or the minute... [when]... her heart rate was really low, it just felt like an hour. It just felt like forever. We were just paralysed. None of us could do anything and the students were looking at us and expecting us to do something... and we just couldn't do anything. It was really, really terrible. And anyhow, luckily her heart rate started catching up again and suddenly her heart was beating around sixty again. (L144)

There were several significant features to this ethical situation. The ethical problem faced by Lucy and Gerri occurred as a result of the hierarchical organisation of cardio-thoracic surgery. As doctors were institutionally responsible for the resuscitation status of patients, nurses were dependent on their decision-making. In this case the ethical problem presented itself because, in Lucy's opinion, doctors failed to make an appropriate decision and declare the patient 'not for resuscitation'. Lucy felt the patient's resuscitation status needed to be addressed urgently but that "doctors just didn't want to listen." In fact, Gerri thought there was an "unwritten policy" amongst doctors not to write DNAR orders even for the terminally ill. It was a situation where nurses felt they had certain moral responsibilities towards the patient, but the power to make decisions was in the hands of doctors.

Lucy described the situation as an "ethical dilemma". It was difficult for Lucy to decide what action to take because she was faced with a choice of competing moral obligations. On the one hand, without a documented DNAR order, she had a professional and institutional obligation to attempt to resuscitate the patient if

necessary. On the other hand, she had professional and moral obligations of beneficence and non-maleficence, which suggested that to attempt to resuscitate a terminally ill patient was inappropriate as it would have caused her pain and denied her a “peaceful death”. Lucy could not do both.

Another feature of this ethical situation was that it emphasised the importance of the nurse/patient relationship. Both Lucy and Gerri had cared for the patient over a long period of time and knew her well. Lucy described the patient as a “really nice lady” and explained how she had witnessed her deterioration due to pulmonary and abdominal cancer. In fact, Lucy’s description of the event suggests she found it morally distressing. She described her experience as “... awful, the worst thing I’ve ever lived through I think” (L186). Part of Lucy’s distress was related to the moral uncertainty she experienced. She was troubled by the thought that she was professionally expected to comply with institutional policy that would have involved her in taking actions she considered harmful to the patient and therefore unethical. Lucy remained uncertain as to what to do if the situation occurred again. She commented:

... but the worst thing is... even today, if it still happened again I don’t know if I could actually do the resus. I don’t know whether I literally physically could start pumping on her, breaking her ribs and start doing the resus. I don’t think I could. It was just terrible. I’d just probably have stood there and waited until she was dead and then start to resus. You know, I just couldn’t do it. It was just so bad. (L192)

In fact, there was more to this incident. Both Lucy and Gerri described how doctors organised for the patient to be transferred to another ward. Both Lucy and Gerri thought transferring a terminally ill and dying patient to another ward was not in her best interests, and were disturbed at the thought of having to do so. Gerri also thought it was important to respect the patient’s autonomy and to consider what she wanted. Gerri pointed out that the patient had been on the ward for months and had always “... expressed a wish to stay with us” (G75). Gerri thought nurses should have opposed the decision made by doctors to transfer the patient, and should have “... put [their] foot down and demanded that she wasn’t moved to the other ward. That she died in peace in the one place and wasn’t just carted off to some place and dumped somewhere else” (G77). In the end nurses felt obliged to transfer the patient. This was an action Lucy

and Gerri thought harmful to the patient, and morally distressing to themselves. Lucy commented:

And because we couldn't get the doctors to sort out her resus status we literally had to transfer a dying lady onto the oncology wards so that the doctors there could sort out her resus status. She got onto the oncology ward, stayed for about twenty minutes and passed away. And we had to transfer this dying lady through the corridors because our doctors... refused to sort out her resus status. I thought that was terrible. (L175)

Second example – nurses had to resuscitate a terminally ill man because doctors would not document their DNAR order

Several nurses recalled an incident where doctors instructed nurses that a terminally ill and dying patient was not for resuscitation but, despite nurse requests, refused to document this. Without such documentation, nurses were professionally and institutionally required to resuscitate the dying man. Quincy described the situation in detail:

... we had a gentleman who was terminal and the doctors wouldn't write, "not for resuscitation" in his notes, but they said that we didn't have to do anything if he died. But it is this whole thing that we are not covered to leave someone to die and I didn't think it was very fair to put a man through a resuscitation process if he wasn't going to survive and that they wouldn't let him die with dignity. And this was a big problem because... from the consultant down they would not write in his notes that he was not for resus... He was a gentleman who was basically a down and out. He came in and... basically he went down hill... He was actually quite young. He was only in his forties. But you can see when somebody is dying. And, it's like, they decided that they weren't going to do anything else. But, the consultant was scared... in case he'd get sued at a later date. (Q189)

As with the first example discussed above, nurses faced this ethical problem as a result of the hierarchical organisation of cardio-thoracic surgery. Doctors were institutionally responsible for the resuscitation status of patients and were required to document DNAR decisions in patients' notes. Nurses were therefore dependent on the decision-making of doctors and relied on them to follow the correct procedure and document their decision. Quincy thought the consultant failed to do so because he was fearful of future litigation. Whatever the reason, the situation was another example where nurses

felt they had certain moral responsibilities towards the patient, but the institutional decision-making power was in the hands of doctors.

In the event, the patient did have a cardiac arrest. Zoe was on duty at the time and had just commenced her night shift. She was aware that without a documented DNAR order she was professionally obliged to initiate resuscitation. Zoe described her situation as a legal and ethical dilemma and was angry that she was put in that position both for herself and the patient. She commented:

So unfortunately I came on that shift and was left with that decision because by law I am required to put out a resus order if it is not written down. And the patient did arrest within half-hour of me coming on the shift. So it was an awful ethical as well as legal dilemma I was in. And I was so angry that I had been put in that position not just for me, just for the patient as well... It's incidents like that, you know, they don't help working relationships. (Z183)

Zoe considered the situation to be an ethical dilemma for her because she felt professionally obligated to commence resuscitation, but felt it was morally inappropriate to do so because the patient had no chance of survival. Zoe explained the ethical nature of the decision she faced and what she did:

... obviously I had to put the call out, but I... knew he had no chance of survival... and... I had to decide... how aggressively I would resus him till the team come... it was all quite horrendous really. So I had an ethical decision to make. How actively I was going to resus him as well?.. I started basic resus only and I kept that going till the team arrived. And I explained what the situation was and together we all came to the decision that there was no point in carrying on. We... knew he wasn't going to recover anyway, he was cheyne-stoking at this point, so we made the decision together. (Z194)

Zoe's decision-making was influenced by a number of ethical considerations. She was clearly concerned to act in what she felt was the patient's best interests. Zoe felt that to have aggressively resuscitated the patient would have denied him a dignified death and would have prolonged a life dependent on a ventilator and without "quality". She commented that full resuscitation would have resulted in "... such an undignified death, being thrown around, thumped on his chest... [and]... we knew if he ever got on a ventilator he would never get back off it" (Z272).

Zoe was also concerned to respect the patient's autonomy and do what he would have wanted. The patient's previous actions had suggested to Zoe that he would not have wanted to be resuscitated. Zoe explained:

He wouldn't comply. He wouldn't take any medications. That was when he was conscious. As he was getting into the semi-conscious stage he would pull out any attempted nutrition, any attempted hydration, wouldn't take food, drink, medicines, nothing. And himself, he was a very aggressive man as well. You couldn't basically get near him. It took an awful lot just to try and get through on a communication level. So he was expressing the fact that he wasn't going to participate in his care but would never actually come out, he never actually said, "I want to die, leave me alone." But that was all the signals that he was pointing to when he was in the semi-conscious stage. As soon as he would come round he would say, "Just leave me alone, don't do anything." (Z214)

Zoe also considered what she described as the patient's "terrible" social circumstances. She thought making a quality of life assessment on another person was a difficult thing to do, and was sensitive about doing so. Zoe asked herself "... who was I to make that decision about his quality of life?" Having said this, her assessment of the patient's quality of life supported her belief that he would not have wanted to be resuscitated. Zoe explained:

Basically he was a homeless tramp person. He had been living on the streets for about twenty odd years. He refused to give any next of kin or any person to whom we could contact at all. Absolutely refused. And that was difficult as well. As I say, he wouldn't participate in any aspect of his care at all. He just did not want to know and I felt that he had given up quite some time before that. He had come through surgery, just, but never really made it after that. So, there was no one there around for him... which is quite sad. (Z282)

Zoe felt it was an "awful" decision to make and after having made the decision to commence only basic resuscitation until the team arrived, she still questioned whether or not she had made the right decision. She commented:

And it's an awful decision to make because it's like, would you make a different decision if you had the family around. If he had a very supportive family would I have made the same decision? I don't know. You know? But it's like I say, if you try to view the whole thing, quality

of life... his condition, what he had was a degenerative thing. So it would not have got any better. It would have just actually deteriorated to the point where he would be on a ventilator and not get off it. (Z299)

Zoe felt the ethical decision was “thrust” upon her “... because nobody else above [her] would make it” (Z275). She found it particularly difficult because she faced the situation alone and unsupported whilst on night duty (Z252). In fact, Zoe’s description of the event indicates she found it an upsetting experience and she appears to have experienced moral distress at having to resuscitate the patient, and moral outrage at the decision-making of doctors. She also spoke of her frustration at her lack of control over the decision-making process regarding the patient’s resuscitation status and her sense of demotivation as a result. Zoe commented:

... if you really feel strongly about something and you don’t get anywhere how ever hard you try to get things done then that’s when you take it in on yourself as well and you become demotivated I think. When you want to change things but can’t... It’s a problem of not having an input in the decision-making processes, which I think can make you feel quite frustrated. And as I say, not having that input is on a day to day basis. You stand up for what you think needs doing that’s when you can have arguments with doctors... (Z457)

Zoe explained how she felt “impotent” in the decision-making process and, while she did feel supported by her peers, this was a factor in her deciding to leave nursing. She commented:

... it generally helps if you have within your peers a very good support group, which we do have, but just within your peers, on this particular ward. So that’s fine, we do go home, we do let off steam and we talk about things. But I think ultimately it’s not really as effective because we do feel, being honest here, impotent about having a say in the decisions what are made on the ward. I’m leaving so that tells a story. And I’m leaving nursing so that tells an even bigger story. (Z483)

Zoe’s decision not only to leave the ward but also to leave nursing altogether could be viewed as an example of exiting (Hirschman, 1970), a form of resistance to a process of hierarchical decision-making that conflicted with her own moral position.

Both Winny and Quincy also spoke of the incident, though they were not on duty when the patient arrested. They differed over what action should have been taken. Winny

reasoned that nurses were legally obliged to initiate resuscitation despite feeling it was ethically wrong to do so. She thought it was undignified for the patient and she applied the so-called 'Golden Rule' when she said, "... I did not think that it would be very dignified to be resuscitating somebody under those circumstances. If it was my relative, my mother or my father or my husband, I would not have wanted them to be put through that" (W206). Quincy also thought the patient should not have been for resuscitation and should have been allowed to die with dignity. However, with respect to what actions he would have taken, Quincy thought he would have left the patient and not started resuscitation, despite his belief that he was legally obliged to do so (Q216).

The incident highlighted the hierarchical nature of the professional relationship nurses had with doctors and some of the ethical difficulties this caused them. Winny, as a junior sister, was concerned that nurses had been put in such a difficult situation and that the patient had been subjected to inappropriate treatment because doctors had declined, despite hospital policy, to document that he was not for resuscitation. Winny explained the actions she took:

I felt very unhappy about this and did not really feel that I could follow these instructions without there being some documentation. The patient clearly was a patient that wasn't suitable for to be resuscitated and I had no problem with that at all. I spoke to the registrar that was on call and he was quite adamant that it was not going to be written in the notes and again said that the consultant hadn't wanted it documented. I spoke to the duty manager and between us we decided that if this patient did arrest we would have no alternative but to put out a crash call because there was nothing to say legally that this was what, you know, we couldn't do. I found that very, very difficult. I mean it was something that was addressed afterwards and the consultant and the registrar concerned I think did agree afterwards... perhaps that they weren't right in not having some documentation in the notes. (W60)

Despite the difficulties and distress this incident caused the nurses involved, they were never given an explanation by doctors of their behaviour or why, despite hospital policy, they declined to document their DNAR order. In fact, when Winny raised the issue she appears to have been treated rather dismissively by some doctors. She commented, "I felt very strongly that we should not have been put in that position... when I highlighted it... the reaction I got was... I was making a fuss about nothing"

(W142). The incident was eventually formally investigated. Winny explained that, "... it got to quite a high level. And the medical team concerned agreed that it should not have happened and it did leave the nursing staff in a position, and in future it must be clearly documented in notes if the patient is not to be resuscitated" (W179).

Third example – the patient who did not want to be resuscitated

The final example illustrating the ethical problems faced by nurses with respect to the issue of resuscitation involved Xaria, a newly qualified nurse who had recently joined the ward. She described how a female patient who had suffered cardio-respiratory arrests in the past requested that she not be resuscitated if she had a further cardio-respiratory arrest. Xaria was concerned at the way in which doctors dealt with the patient's request. She described the incident:

There was a patient, she had actually come in for surgery for the second or third time and her past experiences were not very good. She had had a couple of arrests and she wasn't very happy about it. She was literally pleading that she doesn't want to be resuscitated again... It was the way it was handled by the team. About three or four of the doctors just straight away walked out as soon as the patient mentioned it... They just stood outside and started to have their little chat and giggle and whatever... the consultant, he listened. I admittedly say he did listen to the patient. I think in his own way he tried to reassure her that we would try and do as you wish but, there was a "but" there. You know, this is what is going to happen. And I think he was trying to force that on her. It lasted... five minutes this whole thing and then afterwards, later on in the day, when I went to... the patient she was still worried sick... she was not happy... with the way the doctors listened or the answer they gave... I don't think she was heard or her wishes were met. (X400)

Xaria's main ethical concern was for the autonomy of the patient. She thought the patient's wishes were not being respected and she was not being listened to. Xaria spoke to the patient and listened to her. She felt the patient might have needed more information in order to make an informed choice and was concerned about the patient's mental state of mind. Xaria also spoke to the sister about the situation. She continued:

I listened to her mainly because I didn't know the ins and outs of it... come what may, she didn't want to be resuscitated if anything happens... she was mainly unhappy about the way the doctors had handled it. That they were not listening to her; they weren't listening to her wishes... I

admit she... probably needed more information and I did say that to her... It was as if there was a mood of, "I don't care anymore" in her... But that really did bug me for a while. I actually tried to speak to one of the sisters about it but I think she wasn't happy with the way the doctors had handled it either and she said that she would have to discuss it with the doctors before she could give anyone an answer. She did call all the nurses in and [said]... if she did arrest at any time on the ward this is what we were to do and this is what we were not to do, [the patient was to be resuscitated]. (X430)

Xaria described how she and other nurses were unhappy at the prospect of having to attempt to resuscitate the patient. She felt it disrespected the patient's rights and her expressed wishes.

In this incident, as in the two previous examples, nurses faced ethical difficulties as a result of the decision-making of doctors. Xaria felt doctors failed to make a decision regarding the patient's resuscitation status, thereby leaving the situation vague and nurses in a state of uncertainty. She explained:

... her rights as a person weren't being respected basically. If she wished that, then who are we to say, "No, this is going to happen?" That's why, three nurses, including myself... weren't happy with any decision that was made because I don't think anything was made. It was just assumptions. The doctors said, "This, this and this." Then they shot off. The sister is looking at them and it was like, "O, right, this is going to happen," and then pass it down to the nurses. You know, like Chinese whispers, by the time you get to the third and fourth person it's like, "Are you sure? Well maybe, maybe not." There was not a definite decision. If you are going to make a decision, especially something like this, its you must know or you don't know. That really bugged me. (X456)

In the absence of a documented DNAR decision, Xaria felt doctors had in fact made the decision to resuscitate the patient against her wishes. In the event, the patient had surgery, recovered and was discharged home without incident. However, according to Xaria's account a paternalistic attitude was adopted to override the wishes of what appeared to be a competent patient. Though, given the patient's "mood" there was doubt as to whether the wish not to be resuscitated was a sustained one. Despite this Xaria concluded:

From what I can see she was quite happy... she was ok... No event happened but that's not the point. The point is she was not listened to. Her

wishes were not respected then. It was, “We know better than you. We are going to do this whether you want us to or not.” That was the attitude. She wasn’t elderly, she seemed quite with it, she knew what she wanted and what she didn’t want. (X495)

Summary

Many nurses raised the ethical problems associated with the issue of resuscitation. Such problems had their origin in the hierarchical organisation of cardio-thoracic surgery. Doctors were responsible for the resuscitation status of patients and were legally and institutionally required to document DNAR decisions they made. Nurses were institutionally and professionally required to comply with doctors’ decisions in this respect and faced ethical problems when they considered such decisions were not in the best interests of patients or were harmful to them.

From the three incidents examined certain ethical components were identified. The ethical concerns of nurses were patient-centred. They were concerned for the best interests of patients and that they were not harmed. This suggests the principles of beneficence and non-maleficence were important considerations. Resuscitating terminally ill and dying patients, for example, deprived them of a peaceful and dignified death. Nurses were also concerned to respect patient autonomy by taking into account their wishes with respect to resuscitation decisions. In this regard the nurse/patient relationship was significant as nurses often cared for patients over a long period of time, had close contact with them, and were often aware of their wishes. Nurses identified some of the problems they faced as ethical dilemmas, where they were presented with difficult ethical choices that involved competing moral obligations. Finally, nurses were distressed and upset by certain incidents, particularly when they felt institutionally and organisationally pressurised to act in a way they considered harmful to patients. Nurses experienced moral distress when troubled by the moral choices they faced and when they felt unable to resolve them.

CHAPTER SUMMARY AND CONCLUSION

By examining the issues of late cancellation of patient surgery, patient discharge and planning, and resuscitation, the diverse and complex ethical nature of the ward

environment and the variety of ethical problems experienced by nurses are further illuminated. Nurses felt ethical problems were often caused by the “conveyor belt” organisation of cardio-thoracic surgery and a lack of resources. Professional and power relations were also of concern. Nurses were particularly concerned at the hierarchical nature of the decision-making process and the fact that they had little say in it. In many instances doctors were the empowered decision-makers and ethical problems arose when nurses were professionally and organisationally obligated to comply with decisions they believed were contrary to the best interests of patients and potentially harmful. Nurses cited examples were, for example, they were expected to discharge patients prematurely, and to resuscitate the terminally ill and dying. In such circumstances nurses experienced both moral distress and moral outrage.

Despite this, nurses practised resistance and active decision-making. Their response to ethical difficulties was motivated by a wish to act in the best interests of patients and to ensure they were not harmed. This suggests the principles of beneficence and non-maleficence were important to them. The professional relationship with patients was central to the ethical experience of nurses. Emotional involvement and empathetic understanding, knowledge of the psycho-social health and personal wishes of patients, respect for patient autonomy, and concern at the possibility of the loss of patient trust, were important features of this relationship.

We have seen in this chapter that in response to ethical problems nurses made choices and took certain actions. They forewarned patients of the possibility that their surgery may be cancelled. They assumed the role of informing patients when their surgery was cancelled in order that they could be relieved of the discomfort of being ‘nil by mouth’. They resisted pressure to discharge patients prematurely and insisted that patients were psycho-socially as well as physically prepared. They formulated discharge criteria and pursued a policy of organising proactively in order to lead the discharge process. They spoke up against resuscitation decisions they thought contrary to the best interests of patients. Nurses constantly thought about and made difficult ethical decisions. It is the purpose of the next chapter to focus on the ways in which nurses made such decisions and to examine their ethical reasoning and decision-making.

CHAPTER FIVE

ETHICAL REASONING AND DECISION-MAKING

Having in preceding chapters examined the environmental context and some of the ethical experiences of nurses the aim in this chapter is to consider in more detail their ethical reasoning and decision-making. The chapter is divided into two sections. The first examines the importance of the nurse-patient relationship. The second examines the importance of character and virtues, and the role of conscience and guilt. The chapter finishes with a conclusion.

THE IMPORTANCE OF THE NURSE-PATIENT RELATIONSHIP

Nurses often spoke of their relationship with patients, such that it appeared to lie at the heart of their ethical reasoning and decision-making. This emphasis is characteristic of the ethics of care approach to ethical reasoning and decision-making. Lützén et al. (1997) also found, when researching moral sensitivity amongst Swedish psychiatric and medical-surgical nurses, that female nurses in particular identified their relationship with the patient as the most important aspect of their work.

Nurses considered they had a close relationship with the patients. They spent much time with patients, cared for them over long periods and got to know them well. In the discussion so far we have seen a number of examples of this. Rebecca spoke of caring for a patient for a “few days” and developing “quite a relationship with him”, and how “upset” she was when he developed a pneumothorax after, on the instructions of a doctor, she removed a patient’s chest drain (R201). When Quincy spoke of the patient who died the evening her surgery had been cancelled for the third time, he pointed out that it was very “difficult” for nurses and “caused a lot of upset” particularly because nurses had cared for the patient for over six months (Q97). We have seen also how Gerri and Lucy opposed the idea of moving the dying patient to another ward because

the patient had been on the ward for months, they had got to know her well, and were aware of what she would have wanted.

This part of the chapter explores the way in which the ethical reasoning and decision-making of nurses was influenced by their relationship with patients. It explores first features characteristic of the relationship-based ethical reasoning and decision-making of nurses, and secondly specific patient-centred concerns to which nurses commonly referred.

Features characteristic of relationship-based ethical reasoning and decision-making

In the ethical reasoning and decision-making of nurses several features commonly arose that related to their relationship with patients. They were the importance of beneficence and non-maleficence, emotional involvement, the use of empathetic insight, applying the Golden Rule, and having a duty of care.

Beneficence and non-maleficence

Within the context of their relationship with patients, the principles of beneficence and non-maleficence were central to the ethical reasoning and decision-making of nurses. The importance of these two principles is recognised in health care ethics (Beauchamp and Childress, 2001). Nurses often emphasised that their reasoning was influenced by the desire to act in the best interests of patients and to ensure they came to no harm. In this respect nurses were involved in teleological reasoning in order to determine actions that would produce desired consequences. However, their use of teleological thinking appeared different from the utilitarian thinking often found in the literature. It was influenced by the relationship nurses had with patients and often focused on consequences for individual patients rather than for general utilitarian benefit. Teleological thinking of this sort was evident in many of the incidents nurses referred to regarding late cancellation of patient surgery, patient discharge and planning, and resuscitation discussed in the previous chapter.

Some nurses referred explicitly to the priority they would give in their ethical reasoning to beneficence or non-maleficence, some prioritising the former while others the later. Quincy, for example, emphasised within the context of his patient-centred reasoning the importance of beneficence when he commented, "... my patients are always my first priority... the main thing is the patient, what is best for the patient" (Q714). Pat also emphasised beneficence. For her the main priority was what was best for patients, even if it meant having to resist hierarchical pressure from doctors. Pat explained:

When it is a decision about patient care I'd be thinking what's best for the patient when I'm making a decision. In the back of my mind it would be, "I might get into trouble with the doctors because of what I'm doing." But I still do what I consider is best for the patient. I would never do anything that I'm not sure about anyway and if I wasn't sure about something I would take the doctors advice. But if I am sure that something is not right then I'd do what I feel is best for the patient care. (P536)

Hilary and Ursula, on the other hand, emphasised the importance of non-maleficence. Hilary spoke of "patient safety" coming first in her ethical thinking, ahead of other priorities such as good patient care, the mental health or happiness of ward staff, care of patients' relatives, administrative paperwork and environmental cleanliness. Hilary explained:

Well I think patient safety has to come first. And then, patient care is next... You have got to be able to care for the patients, they've got to be clean, fed, wounds looked after, problems noted. And then... the mental health or happiness of my staff is quite important. Because if the staff are unhappy they won't come to work or they will be sick or they'll leave... And care of the relatives as well. Those kind of things. And maybe I'm different from other people but I like to get all my paperwork done. But that is what comes at the bottom of the pile... The other things are, the environment... I mean, the cleanliness of the environment, the tidiness of it. That's one of the priorities, because I think that all goes in with how the patients feel. If it is a complete pig's sty, it's a bit embarrassing. The relatives come in and find the place is a complete mess and the beds haven't been made and there is rubbish all over the place. It doesn't look good, does it? And it doesn't make the patient feel comfortable and rested. (H628&656)

Ursula also emphasised non-maleficence. She believed the role of nurses was twofold, to do no harm and to do the best possible for patients. Doing the best possible often meant working within environmental constraints such as limited resources. Ursula explained:

Basically... we are here to do the patients no harm. We should try to do the best for the patients that we can. And basically we should try to do the best for the patient in that individual situation... But I think to a degree as well that you have to realise that we haven't got infinite resources and so sometimes to perhaps attain the standards that we want would be impossible so you have to use the best that you've got within that situation. (U600)

Emotional involvement

Emotional involvement was an important feature of the relationship nurses had with patients. The importance of emotional labour in nursing and its relationship to care has been emphasised (Smith, 1992). However, while emotional labour is important in the healing process it is often invisible, and the fact that affective relationships become part of the emotional labour of nurses is not always acknowledged (Mowforth, 1999b:47). The ethical reasoning and decision-making of nurses in this study took place within the context of their emotional involvement and was influenced by it. Emphasising the importance of emotional involvement is representative of the ethic of care approach (Beauchamp and Childress, 2001:373), and indicates that the ethical reasoning and decision-making of nurses was conducted in an involved and partialist manner, rather than in a detached and impartial way characteristic of traditional theory.

Many nurses referred to the emotional involvement they experienced. They spoke of both the emotional distress they experienced as well as the emotional rewards they gained. In some cases emotional distress was long lasting. Sally, for example, referred to the incident where a young man died while she was on night duty and said that it took "... six months and more before I could put it out of my head" (S123SN). She questioned her actions for months after, before concluded her actions were the right ones. Rebecca's experience over the chest drain incident was similar. She repeatedly questioned her role in the incident and pointed out that the incident was "... one of

those incidences which has stuck with me throughout” (R196).

Jane also referred to the issue of emotional involvement and felt it was part of nursing. She thought nursing was different from most other jobs in that nurses were involved with the feelings of others and sometimes it was not easy for the nurse to go home and simply unwind. Jane explained, “... there are times when you go home and you can’t even unwind if something has happened. You sort of take it home with you... it is sort of part of the job really” (J299).

Alongside their experience of emotional distress, nurses also spoke of the emotional rewards of nursing and how this served to motivate them. Xaria, for example, pointed out how she would feel good when patients appreciated the care she had given. For Xaria the appreciation of patients served to confirm the appropriateness of the care she had given. She explained:

... there have been times where patients have said, “Will you look after me tomorrow?” That makes me feel good. I feel as though I have done something right if they are asking for me again. It’s the way they say it basically. You know that they have liked something that you have done... And when they talk to you while you are doing your work... just personal day by day conversation, like, “Where do you live.” “Are you married...” And they are interested in where you’re studying... and then they comment on that... That makes me feel good. Especially when patients say, “Can you look after me tomorrow?” (X245)

Hilary also thought it was emotionally rewarding for nurses when patients were grateful for the nursing care they received, even if she felt the quality of that care was limited by lack of resources. Hilary commented:

It can be rewarding. It has its moments and sometimes you can be slagged off left, right and centre by relative or patients. But most of the patients I think are quite grateful for the care... they leave gifts for us, chocolates and ‘thank you’ letters a lot of the time. And I sometimes think, “Why, did we really give you good enough care?” But perhaps it’s the age of a lot of our patients. A lot of them have been through the war. They’ve had quite hard lives, perhaps. And perhaps being on a ward which isn’t maybe that clean with not that many people looking after them... isn’t that bad after all. (H709)

Hilary felt the emotional rewards of nursing motivated nurses and kept them going

despite all the problems they faced. She referred to the difficulty nurses faced and asked:

... but why are we here though? You know, we are still here. It's quite rewarding really if you can get above all these problems. And you only need one patient to say, "Thank you very much, that was really nice, I feel so much better now you've done that." And that keeps you going... (H516)

However, some nurses thought there were dangers in fostering close professional relations with patients. If nurses became too emotionally involved this might reduce their capacity to care. Winny, for example, spoke of her experiences nursing in specialist heart/lung transplantation units. She explained how it was emotionally difficult for both the patient and nurses when a patient had been on the ward for a long period, and without a transplant was gradually deteriorating. Winny explained:

It was difficult when you had somebody on the ward that was waiting for a couple of months and they didn't make it. That was difficult, very difficult for them and for the nursing staff as well. You would live through it with them every day. You could see them deteriorate. There were patients totally dependent on oxygen, unable to move. You know that this transplant was their only chance of life and that life was slowly ebbing away while they were waiting... It is very difficult... [because]... you can see somebody who is gradually deteriorating. Every breath is a major ordeal for them and their only chance is heart or heart-lung transplant and as each day goes by the chances of them getting it in time is getting less and less. It's difficult. I find it difficult in terms of emotionally you feel very much for them. (W394&431)

However, while Winny thought it was important to give the patient support, she also thought it was necessary, in order to cope emotionally, to maintain a degree of professional detachment. This was necessary in order to be able to function as a nurse and help others. Winny explained:

... [you deal with the situation by being]... supportive to the patient and relatives... [but]... you can't allow yourself to become totally involved with them. In the end of the day you have a job to do and you are not going to be of any use to anybody if you are sort of getting all very emotional yourself. I think just being a support to people, being a listening ear, and showing them that you are there really. (W440)

Winny felt that adopting a degree of professional detachment in order to be able to care for other patients was part of the role of the nurse. However, she thought it was a difficult thing to do, and it helped if the nurse was personally “strong” and able to withdraw from the situation (W466).

Empathetic insight

Related to emotional involvement was the use by nurses of empathetic insight in their ethical reasoning and decision-making. The importance of empathy in therapeutic relations has been stressed (Reynolds, 2000:1), and its altruistic moral motive has been emphasised (Morse, et al. 1992). In this study nurses would sensitively seek to understand and appreciate the experience of patients, often by imagining they were in the patient’s position. Their use of empathetic insight was consistent with the partialist thinking found in the ethic of care approach.

There were many examples where nurses demonstrated empathetic insight. We have already seen in the previous chapter the use of empathetic insight by nurses in response to ethical difficulties associated with the late cancellation of patient surgery. Mandy commented that nurses would “feel” for patients whose surgery had been cancelled at the last moment. She empathised, “... you feel for them, because they do get themselves worked up, and they are told to come in and then they are cancelled... it’s hard to tell them although it can’t be helped at times” (M300). Mandy’s empathetic concern extended not only to the patient but also to the patient’s family:

We get patients coming in who just get themselves that geared up to come in... they’ve spoke to family and they don’t know if they are going to go back or not. And it is a big thing. They’ve said, “Goodbye” or “See you later” and they are going to have to go through it all again. I know it can’t be helped at times but it is not something that is nice... they were in tears because they’d been cancelled... It’s horrible. I mean, it is not just for patients as well, it’s the families, you know, wives. It is not nice. (M333)

One way in which nurses demonstrated empathetic insight was by recognising that patient’s sometimes felt intimidated and vulnerable. Lützén et al. (1997) found that

nurse recognition of patient vulnerability was an important part of ethical sensitivity. Winny, for example, referred to the intimidation of the ward-round:

... it can be quite intimidating when you go round on a ward-round. You know, six or seven people, everybody standing up and the patient is on the bed and we are all looking down on him. There may be this medical jargon that the patient doesn't understand. He may be hard of hearing, may not quite pick up, heard bits of it. It's very difficult and I think that as a nurse we are very much aware of all that and you are sensitive to what you think the patient has picked up. You are reading their non-verbal cues... there are certainly patients who still have this thing that they don't want to keep the doctor or the medical staff or even the nursing staff because they feel they are taking up your time. (W685)

Kerry made similar observations. She thought patients were sometimes overwhelmed and reluctant to ask questions when doctors were seeking their informed consent. Kerry explained:

I think in a speciality like this people generally can be quite overwhelmed by it all. They don't really understand and they do see the doctors that can do this life-saving surgery as gods in white coats. And they don't want to ask questions and get in the way, like, "These doctors are all powerful, they know what they are doing, so we will just trust them." And then they daren't ask questions. It happens every day. They do the ward-round and then the nurse goes in afterwards and they'll ask you all the questions they should have asked the doctors. But they don't want to ask the doctors because they are busy. I'm sure that happens everywhere else as well. (K220)

Being empathetic was on occasions similar to applying the Golden Rule where nurses would imagine themselves in the patient's situation as a means of determining what action to take. But Mandy noted a word of caution. Empathy, she thought, was not simply asking yourself how you would feel if in the position of the patient and then assuming how the patient felt. It was more than that. It was putting yourself in the position of patients and trying to see and experience things from their point of view. When Mandy was asked what attitude she felt nurses should have towards patients, she replied:

... listening and just caring for them really. You know... empathy... Just putting yourself in their shoes... How you would like to be treated, I think... then again... I mean, not so much as how you'd feel if it was you

but how they might be feeling. I mean, what they feel is probably different. But try to think of it from their point of view...Yea, I mean, what you might feel isn't necessarily what they're going to feel. But just try to look at it from their point of view really. (M787)

The Golden Rule

Nurses commonly applied the Golden Rule in their ethical reasoning and decision-making. The Golden Rule is often equated with the biblical directive found in Matthew 7:12, "... so in everything, do to others what you would have them do to you..." (Sidgwick, 1994; Rosenstand, 1994). It is therefore representative of the theory of reciprocity. Nurses used the Golden Rule when they imagined themselves, or a family member, in the position of the patient and then determined their action by considering what they would want for themselves (the Golden Rule), or family members, (the Golden Rule by Proxy). In using the Golden Rule nurses would apply their own values and preferences to a situation in order to determine what they thought was best for patients. It demonstrated that their ethical reasoning and decision-making was to some extent determined by their character, their values, and the way they perceived themselves and others.

Applying the Golden Rule could be problematic. By putting themselves in the position of patients and applying personal values and preferences nurses might gain some idea of what actions would be in the best interests of patients, particularly if patients had the same values and preferences, but there was no certainty of this. Mandy's word of caution that it was important to consider how the patient might feel rather than how you, as the nurse, might feel when empathetically putting yourself in the position of the patient was relevant when applying the Golden Rule.

There were many examples of nurses applying the Golden Rule. It was commonly applied when considering the issue of truthfulness and the disclosure of information. Val, for example, did so when discussing the issue of cancer. "If it was me", she said, "and if I thought I had got cancer and I almost knew, and the doctor just told me that I had a tumour... I would ask..." (V638). Similarly, when Gerri said she thought thoracic patients had to wait too long before they were informed of their diagnosis and prognosis, she applied the Golden Rule and commented:

Well, I think that if I've had some lump inside me. And I went to the doctors and he sent me off and they cut it out, I know that personally, the first thing I would want to know is "What is it? And what are you going to do about it? And am I going to survive it or is there no hope?"... And... I'm Mrs Average. (G331)

Still on the issue of truthfulness and the disclosure of information, Kerry applied the Golden Rule by Proxy when she considered the request by doctors that nurses not inform patients or relatives about surgical mistakes in theatres. Despite going along with the request, Kerry reasoned that it was wrong because, "... if that was your father or mother in that bed you would want to know exactly what happened" (K124).

Nurses also applied the Golden Rule when they considered the issues of resuscitation and patients dying. Mandy, for example, thought about the incident where doctors declined to make a DNAR order on a patient who was terminally ill and dying of cancer and reasoned, "... but if it was me I wouldn't want anybody jumping up and down on me if the inevitable is going to happen any way" (M90). Quincy also applied the Golden Rule. When asked to explain how he defined the best interests of the patient, he commented:

It's the sort of thing about how you would like to be treated yourself no matter what sort of situation. You know, if they are dying, I want them to die comfortable, pain-free and as dignified as possible. If they are sick, I want the maximum medical input put into that person to try to get them better. (Q714)

Hilary thought nurses applied the Golden Rule by Proxy as a yardstick for determining the appropriate standard of care required of them. She explained, "... you think of the patient as, 'this could be my mother or my father or a relative.' And you know how you'd want them to be treated" (H171). When asked if she would expand on her understanding of the Golden Rule, Hilary commented:

I don't... [think]... people consciously think it all the time. But I mean, if I go into the ladies toilets and I look at them and I think that they aren't very clean, sometimes I think, "Would I like to be a patient here and use that toilet?" Or, if it was my mum what would I think and what would she think. If I knew that somebody had been left without being washed for a week, I wouldn't be very impressed. But I think of it perhaps in

terms of myself or one of my family. (H363)

Gerri also referred to the use of the Golden Rule. When asked if she had a personal philosophy about nursing she replied, "... I always try to work along the lines of, do for these people what you would like done for you if you were in their situation, or what you would like done for your mum, granddad, brother, whatever" (G661). Gerri continued by saying that she thought the Golden Rule was helpful in setting acceptable standards and illustrated her view with a useful example. She commented:

Well, I suppose it... sets a standard that you can work to... it is like that old saying, isn't it? "Do unto others as you would have done unto yourself"... I use it all the time. You know, sometimes somebody will be screaming out, "I want three blankets, I want three blankets." And, you know, at the time you don't want to get them a blanket. You haven't really got the time and there are other things you could be doing, the cupboard is all the way up the end of the ward... But then you just have to stop and think, "Well if I was cold, and I wanted a blanket and I couldn't go and get it myself, I would like to think that somebody would just take five minutes just to get me a blanket." That's a very simple example. (G680&689)

Jane recalled an incident she experienced in another hospital. Her description of the incident suggests a link between empathetic concern and the application of the Golden Rule. She empathised with the relatives of a very obese man who had died and who could not be removed from the hospital room because of his size. Jane first explained how she "felt" for the relatives:

... the patient died and they had to keep him in that room for a few days with loads of fans... on him for a day or so, because he was so obese. And when the undertaker came for him they couldn't lift him... So they... [left]... him in that room... I know it could not have been helped but... I felt for the relatives because it was so degrading really. And I just felt that probably they could have dealt with it in a better way. I don't know if it was the undertaker's fault for not measuring the body properly or whatever, but I just felt that it was not the right thing... I felt, not for the person, but for the relatives. I did feel a bit upset for the relatives, seeing the relatives like that, and having all these fans going all night. And the mother was really upset. I just felt for the mother really... because she was really, really upset. (J217&232)

Such was Jane's association with the feelings of the patient's relatives, I asked if she thought nurses put themselves in the position of patients, or in this case the patient's

relatives. Jane's reply suggests nurses used the Golden Rule or in this case the Golden Rule by Proxy. She also thought it was important to think in this way, as empathy was an essential part of nursing. Jane explained:

A lot of nurses say, "I wouldn't like this to happen because that could be my dad or my mum lying there"... I've heard nurses say that... I think a lot of nurses do... I think that is what nursing is all about really. And if you don't think that way, it's like... any other job. You... do what you've got to do and... you go away and that's it. But I think... that is what nursing is all about. You have got to have empathy sometimes with sick patients and their relatives. I feel that. (J284)

A duty of care

Nurses referred either explicitly or implicitly to their duty of care when considering the ethics of their practice. However, their use of deontological thinking differed from that traditionally associated with Kant. It was partial rather than impartial, being closely related to their relationship with patients. Ursula, for example, directly commented, "I think that we nurses do have a duty of care to patients..." (U199). Sally also spoke of her duty of care when she considered some of the wider ethical issues such as lack of resources, late cancellation of patient surgery and waiting lists. She thought there was little she could do with respect to some of these wider issues and that her focus must be concern for her patients. She commented:

So I tend to think that my duty of care is to the patients that I have got... to make sure that they are well and able to go home, and that they are cared for while they're here... And to give a decent standard of care to the... [patients]... I have, instead of slapdash in order to maintain a throughput. (S531)

In many respects, to have a duty of care was implicit in the professional role of the nurse. When Sally first reflected on the traumatic incident where a young patient unexpectedly died while she was in charge on night duty, she felt she had failed in her duty to fulfil her professional role. She commented, "... I just felt it's like a dereliction of duty and I thought I didn't fulfil my role, I didn't support the people I was with and it was my fault he died..." (S82). As time passed she realised she was not to blame and had done all she could.

Nurses thought they had a duty to speak up or act on behalf of patients and to assume what they considered to be the role of patient advocate. Two examples illustrate this. The first involved Winny, who thought she had a duty to speak up in the interests of patients. She was particularly sensitive to the fact that the environment, particularly the ward-round, could intimidate some patients to the extent that they were reluctant to raise their concerns. In such circumstances Winny felt she should act as the patient's advocate. She explained, "In the end of the day I feel that I am the patients advocate... I think that if I am concerned... there is a potential... problem... then I feel in the patient's interest I have got a duty to bring that to the attention of the appropriate person..." (W664).

The second example involved Mandy who also thought she had a responsibility to speak up on behalf of patients and act as their advocate. She felt she had a responsibility to speak up for terminally ill patients when, in the absence of a documented DNAR order, nurses were required to attempt to resuscitate them if they had a cardio-respiratory arrest. Mandy commented:

It's because you're an advocate... I know I can't speak for that person but as near as... When you know there is not much chance and you are pumping up and down on them and doing all sorts to them and in the end they are just going to die anyway. I mean, I know you have got to fight for them but I think there is a limit... (M96)

Mandy also referred to herself as patient advocate when she discussed the situation of a long-stay patient who was very ill. She thought the role of an advocate was not to tell patients what to do but to advise and make suggestions. She commented:

You are an advocate for that patient... He went through a lot and if it was me I wouldn't have been happy at all. He was a very tolerant man... but he had every reason to complain... I mean you are that patient's advocate as far as, not telling them what to do, but mentioning or just suggesting, but... [not to go]... straight over their heads... He was to have some sort of surgery... and the procedure wasn't explained properly and the nurse involved at the time... told him, "Don't sign it... until you get a proper explanation." The SHO was involved then, and she said that she told him not to sign it, and he said, "Well, fair enough if he is not happy about it." Which I was pleased about because he'd been prodded enough... he did pick up. I couldn't believe how well he did in the end... (M467&477)

Specific patient-centred concerns

Linked to the relationship they had with patients, nurses identified a number of patient-centred ethical concerns important in their ethical reasoning and decision-making. The most prominent concerns were for truthfulness and patient trust, for patient autonomy and agreement, for just treatment of patients, for patient confidentiality, and for patients' rights.

Truthfulness and trust

The relationship between nurses and patients was dependent on trust. In order to maintain patient trust nurses advocated truthfulness and honest disclosure of information. The requirement of truthfulness on both a personal and professional level influenced the ethical reasoning and decision-making of nurses. Gold et al. (1995) found that American nurses in acute and long term care valued truth-telling and trust, and identified them as important amongst a number of ethical considerations.

Some nurses referred to their belief in the importance of truthfulness. We have seen in the previous chapter how Sally was upset when she suspected that she was “fobbed off” by theatre staff about the reasons for the late cancellation of a patient's surgery and as a result was inadvertently involved in deceiving patients. On a personal level it was important for Sally that she told the truth. It was also important on a professional level in order that patients might be able to trust her and feel safe in the care that she gave. Sally explained:

It's important for me. I don't want to tell lies. And it is important for them to be given the truth... because they need to trust me and I don't want to sound like I'm making something up... Because... they're there as patients... They're frightened and... [I'm]... handing them out drugs and doing things to them. (S622)

Nurses raised examples where they thought information was withheld or where patients were deceived about their prognosis and diagnosis. Kerry spoke of an incident where doctors instructed nurses not to inform patients or their relatives about surgical mistakes made in theatre. Kerry reasoned that patients had a right to know but

agreed to the request because she believed it was in the interests of patients that nurses maintain a good working relationship with doctors. Val was concerned that some doctors did not inform patients unless they were asked to, or tended to skirt around the issue and used words like “tumour” or “growth”. She reasoned that this was wrong because patients were entitled to know. Val commented:

... the doctors... say, “Don’t tell the patient unless they ask.” Which I think is wrong sometimes. They just skirt around and say, “You’ve got a tumour or a growth.” [It is wrong because]... I just think that they are entitled to know. (V651&657)

Tina also spoke of the importance of being truthful and fully informing patients. She discussed an incident where she was present when a doctor failed to fully inform a woman about her cancer and prognosis. The woman had a pulmonary mesothelioma and a very poor prognosis. In considering the incident, Tina applied several ethical principles (T280-423). The incident is fully explored in the chapter on narrative analysis.

Regarding disclosure of information, Gerri was concerned about the length of time thoracic patients had to wait before being informed of their diagnosis and prognosis. Following surgery or biopsy it was often some time before doctors informed them. Gerri empathised with such patients. She also felt nurses were often in a difficult situation, as they too might not know the diagnosis and prognosis, or they might know but be unaware of what doctors have said to patients. As a result it was often difficult for nurses to know what to say to patients. Gerri explained:

... there does seem to be this recurring problem with lung patients. They get them in and they do their operation and they take off a lump... and they send it off for biopsy and then the persons’ sat there. It can take forever for our doctors to tell them what’s wrong. And you can imagine, or I can imagine, the thing uppermost in their mind has got to be, “Is it cancer? What is it? How long have I got? Am I having chemo or radio?” And, you know, they keep them dangling forever... And who is the first person that the patient turns to? And it is you. And we are always left as well... sometimes you’ll get told... [but]... you don’t know what the doctors have told... [the patient]... it is usually nothing. And then you are like, “Do I tell them...?” You know, it’s not your place... you can say, “O, yea you’ve got cancer.” But you can’t say, “You’re going to

have this treatment” or “You’ll go there”... we are not a specialist cancer ward either. So we haven’t got that great an idea about it. (G287)

Gerri felt patients should be informed of their diagnosis but if the nurse knew the patient’s diagnosis and the patient had not been informed it presented the nurse with a dilemma as to what to do. She explained:

It leaves you in a dilemma because again you’ve got this patient who you know needs to know what’s happening in their life. And you’ve got the doctors who’ve got their own agenda going on. And you are left with the dilemma of what do you do. Do you go in there feet first and tell them? Or, do you wait and hope that the doctors eventually get round to telling them themselves? (G315)

Autonomy and agreement

Concern for patient autonomy and agreement were important considerations in the ethical reasoning and decision-making of nurses. This was consistent with the importance attached to the principle of respect for patient autonomy by Beauchamp and Childress (2001). We have already seen examples where concern for patient autonomy and agreement, and the wish to facilitate patient choice guided nurses’ actions. It was, for example, an important part of Zoe’s ethical reasoning and decision-making when she was faced with the situation of having to resuscitate the young “tramp”. Zoe was concerned for what the patient wanted and the choice he had made. She believed the patient did not want to be resuscitated and had chosen to die.

Jane also spoke of the importance of patient choice and thought it necessary to plan nursing care with the patient and allow the patient choice in doing so. Jane commented:

I think it is a good thing for patients to make their own choices. I mean, choices in everything. I mean, in the old days you could say to the patient, you know, you have a bath today and you drag them to the bath. Nowadays you don’t do that. You talk to your patient as a person. And you sort of plan your care with your patient. And you ask your patient, “Well what would you like to have today? Would you like to have a bath or a wash or a shower?” Or whatever, and it is up to them really what they want. And I think that that should be right across the board really. (J175)

However, Jane thought there might be rare occasions when the principle of beneficence was more important than respecting patient autonomy. Jane referred to an incident where she felt paternalistic intervention was justified and where it was appropriate to overrule the patient's choice. The incident involved a young man who did not want his chest drain removed. Clearly, the patient had no choice in that he had to have his chest drain removed, but Jane still sought his agreement. She reasoned that patients feel better if they are allowed choice. Jane explained:

He was a young guy. And he had a very bad experience in another hospital with drains. And he came here and he was hanging on to this drain. He didn't want anybody to go near to him to take that drain out because of the experience that he has had in the other hospital. And I said, "Well, you know, we've got to remove the drain, you can't keep it in because of you'll get infection"... And just calm him down and say, "Well I know you've had a bad experience but I think we'll do a better job than what you've had done before previously." And eventually he agreed and we took the drain out. And he couldn't believe he said the difference in what he went through before and what happened now. So sometimes you probably might have to overrule them. But I think in everyday things... I think the patient feels better if you... talk to them as a person and you let them choose things... You know, because people tend to forget that patients in hospital are people. (J191)

Lucy also felt it was important to ensure patients both understood and agreed. Lucy said patient understanding and agreement were important considerations in her thinking when making ethical decisions. She commented:

... what goes through my mind... is the fact that I want the patient to understand what I'm about to do whatever I'm doing... the reason why I need to do it, and I want to get an agreement with the patient rather than any disagreement. And even if it takes me an extra ten or twenty minutes to get that agreement, I'd rather sit down and get that agreement before I do anything... Because at the end of the day there is two people involved, you the carer and the patient. And there should be two people agreeing to what happens as well. (L678&690)

As the ward was a surgical ward it was not surprising that several nurses raised the issue of informed consent. The patient's informed consent was required prior to any surgical or invasive procedure and was a process designed to ensure patient understanding and agreement. Jane questioned the validity of the consent given by

some patients because she thought they did not understand what they had consented to. She reasoned that patients had a right to know what they consented to and if they did not understand it was the responsibility of the nurse to intervene. Jane explained:

... the patient would sign the consent form but when you go... to talk to the patient they will tell you that they didn't understand what the doctor said and they don't really know what operation they are going to have, although they signed the consent form. And in that situation I would get the doctor to come back and talk to the patient again. Really sit down and explain what the operation is and make sure that the patient understands what operation they are going for... I would say that is ethical because if a patient is going for an operation I think the patient have a right to know exactly what they are going to have. (J72&85)

Gerri also noted that patients did not always understand the nature of their proposed surgery despite having been through the procedure and having formally given consent by signing the consent form. She commented:

So many times when you read it, and it's lovely. It's all signed in the right places and it's got the date and number on it and then you go to the patient and say, "So, you know why you're having these vein grafts?" [And they say], "No dear, I'm not having vein grafts." Or, "So you know what's involved with this bronchoscopy?" "Well no not really." And that is not necessarily always the doctor's fault. A lot of times patients come in and the doctor will be telling them everything, all about it, and it is just going in one ear and out the other. (G446)

Gerri thought patients had a right to make a fully informed choice, and in particular they should know the possible risks involved. Gerri said she would give the patient as much information as she could and then inform the nurse in charge or the doctor if the patient still did not understand. She explained:

... it's their right to control or having a say in their own body. If they don't know exactly what is going to happen, what the risks are... because I think that is the main thing that doctors tend to leave out. They tell them exactly what they're having done, but they kind of neglect to tell them, "Well yea, your arteries may be lovely but you may be paralysed down your left side"... That's the kind of stuff they leave out usually. And... patients got a right to know that this is the trade-off. You know, this thing may be perfect for you, but you could end up with other problems that may be worse than the one that you started off with. (G469)

Kerry, like Jane and Gerri, also thought it was important to intervene if she thought patient consent was invalid. She commented:

You'd listen to some of the SHOs consenting people and you think, "Ah, it is just a case of sign this form just to say that you are going to have this operation." And that was the consent." I mean, at least that was something that I felt that I could do something about. I could... step in and say, "No, they need to know a bit more than that." (K203)

Kerry continued by saying that she believed informing patients of all the things that could go wrong in surgery might frighten them. Nevertheless they needed to know in order to make choices. Other patients may wish not to know anything. Again that is their choice. Kerry explained:

... it would terrify them as well if we told them all the things that could go wrong, but I do think they need to know that. I mean, some people still walk through the door and say, "Don't tell me anything, just put me to sleep and do it all and I don't want to know anything at all." And that is their choice. (K236)

Several nurses referred to the new consent forms that had recently been introduced to the ward. Kerry felt their effect was to improve the quality of informed consent. They encouraged doctors to inform patients of possible risks with the result that the quality of patient understanding and choice was enhanced. Kerry explained:

... I honestly think that with some people, if they had been made totally aware of the risks they may have thought twice about surgery. Certainly, the high risk people that do go on to have strokes, and you look at them post-op and you think, they could have been more warned. They could have had a bit more of a choice about whether or not they had this major surgery. And the consent has changed definitely since, I've noticed just this last couple of weeks... they have a list of about eight points that they have to discuss at consent. And they have to have it completely spelled out to them that they could have stroke, they could have emboli, they could have heart attacks, all the things that could happen to them, including death. And they have to consent each point. And I think that is something which has changed for the better because I am sure that a lot of people... know it is a big operation but they don't really understand, or they didn't really understand the risks. And that was something that was frustrating as a nurse. You would get these, kind of, eighty-year-olds whose families were insisting that they do want to have surgery. And you would just sit back and think, "Well if only they really understood." So hopefully these new consent forms will address that. (K181)

However, some nurses were critical of the new consent forms. Gerry thought they theoretically improved the quality of consent, but felt doctors did not necessarily inform patients more. She noticed that they tended to fill them in with stock phrases such as “risks explained” rather than complete the sections properly (G487). Jane thought the new consent forms were good in some respects but argued that recent improvement in the quality of patient consent was due, not so much to their introduction, but to the increased possibility of litigation (J138).

Just treatment

A concern for justice was also evident in the ethical thinking and decision-making of nurses. The importance of the principle of justice in health care is recognised (Beauchamp and Childress, 2001). Nurses were concerned that patients were treated fairly and cited a number of incidents where they thought they were not. One example serves as a useful illustration. It involves the perceived injustice of the patients’ operating list. Nurses raised what they thought were the injustices of the way in which patients were listed for surgery. We have already referred to the incident raised by Quincy where a woman who had her surgery cancelled three times died the night of the third cancellation. The patient’s place on the surgical list had been given to another patient whose family had “created a stink” (Q59). Quincy thought this was unfair because the decision should have been made on the basis of clinical need and he believed the case of the woman was the most urgent. Mandy also thought prioritising on the surgical list was unfair when it was based on whom made the most noise rather than who was most entitled. She explained:

... but I find that patients or admissions who make the most noise get seen to first... Their threat to complain or... they just shout louder than somebody who doesn’t speak up for themselves and they are treated first... I don’t think that is fair... when you get people in who have been waiting for surgery... [like]... Mr Atkins, say, who is as quiet as anything and doesn’t say a word and keeps getting cancelled. Then you get the next chap in who is a bit louder and gets seen to first. And I don’t think that is right. (M284)

Mandy also thought that the practice of giving preferential treatment to people because of their status was equally unfair. She felt preferential treatment was given to medical practitioners and reasoned on the basis of egalitarianism that they should not be given priority. Mandy thought it was particularly unfair on the patient whose surgery was cancelled. She commented:

... a few incidences where we've had medical practitioners in as patients and they do get priority over others... I don't think it is just in my opinion. And... they are always first on the list... they're personally seen by the consultant, by the registrar... and by the anaesthetist at night. It just makes me blood boil a bit... because they are just an everyday person... why should they have priority over the ordinary folk? They are perfectly nice people. I'm not saying that. But just because they are a consultant or a GP or whatever... I don't think it is fair... it is just not fair on the bloke who is always getting cancelled... if you've got an everyday man and a medical practitioner waiting, you can bet that the first one on the list is the medic. You can put money on it. It is just how it is. It is not right really. (M316&324)

Mandy also noted that there appeared to exist amongst non-smoking patients a sense of injustice when patients who smoked received their surgery first. She thought it important not to be judgmental and to treat all patients the same. Mandy explained:

... you can speak to patients... with lung cancer and they have never smoked... and they have been cancelled and they know people who have had surgery, still smoking. You know, and you see it from a point of view where you don't judge and you treat everybody the same. You just do. But it must be hard for them. I mean, I don't know how I would feel if it were me... They are just bitter sometimes... They are bitter that they have never smoked... and then people... [who do]... are getting done before them and they are being cancelled. If they have smoked they feel like it is their fault... That's just something that some patients bring up. All you can do is be sympathetic really. You can't spout off what's right and what's wrong. (M385)

Confidentiality

Concern for patient confidentiality was also important in the ethical reasoning and decision-making of nurses. Both Sally and Gerri spoke of the need to respect patient confidentiality. Sally was involved in a particularly traumatic incident where patient confidentiality became an issue for her. The incident is considered in full in the

chapter on narrative analysis. Sally had taken part in a failed attempt to resuscitate a young man who shared a four-bedded bay with three other patients. During the resuscitation other patients left the bay area and were shielded from experiencing the event. Afterwards they asked Sally what had happened. Sally attempted empathetically to appreciate how they felt, but reasoned that information about the patient, his condition, and what had happened was confidential and should not be disclosed to the other patients, particularly as the patient's relatives at that stage did not know he had died. However, Sally thought there needed to be a balance between confidentiality and the need for information of other patients. She reasoned that in order to maintain the trust of other patients she should be honest with them, and while she felt she should not give them details she did inform them that the patient had died. Sally commented that she, "... just thought, 'No that's confidential this information, what's happened and his condition.' But I did need to tell them that he had died. I think maybe because they need to trust me, and if they knew... [and]... I said, 'No, he's very ill' or, 'I can't tell you.' They wouldn't trust me" (S250).

Gerri also raised the issue of patient confidentiality, particularly with respect to telephone enquiries. She thought it necessary to be vigilant and careful with what she said on the phone. Gerri thought that there was the possibility of not only breaching patient confidentiality, but also of inadvertently frightening the patient's relatives or friends. She explained:

... confidentiality with the invention of the telephones... really springs up loads of dilemmas... Obviously, you can't tell who they are because I could ring up and say, "I'm Mr Blogg's aunt" and I'm not, I'm just his neighbour and I'm really nosy. You have always got that. And... if you try to say to them... "Well, I'll be happy to discuss it if they come in"... they kind of think that you are trying to hide something and there is something terribly wrong with Mr Bloggs. (G395)

Gerri explained why she thought confidentiality was so important. She emphasised the importance of empathy, applied the Golden Rule and based her reasoning on respecting patient rights and autonomy. She thought patients had a right to choose what information about themselves they wished to divulge. It was not for others to divulge information about them. Gerri explained:

Well again, being empathetic, I wouldn't want all my ins and outs told to my next door neighbour, lovely as she is. You know, everybody's got the right to divulge what they want to, to who they want to. You know, if you want to tell your milkman about it, that's fine, but you might not necessarily want me to tell your milkman about it. (G408)

Gerri employed strategies she called "get-outs" for ensuring she maintained patient confidentiality when dealing with telephone enquiries. Ultimately she attempted to ensure that the patient chose how much information was given and to whom. Gerri explained:

I think my classic get-out is, "Well, do you want a word with him?" Get them to speak to their relative, friend or whatever. I think that is the classic get-out... you get them to deal with it then... [But this]... get-out... doesn't always work because sometimes they don't want to hear from dad how he is, because he is going to say, "O, I'm fine." And... he is not. And they want to know specifically what's going on... And I personally always feel... like I'm doing something wrong, when I'm giving out information over the phone... And you can also... go up to the patient and say, "It's so-and-so ringing and they want to know how you are, what can we tell them?" That's another thing that can give you an indicator of how far you can go. (G420&439)

Rights

The ethical reasoning and decision-making of nurses was also influenced by a concern for patients' rights, which were perceived as entitlements nurses were duty bound to respect and act upon. Nurses, as illustrated in a number of incidents examined so far, commonly referred to the notion of rights. We have just seen how Gerri thought patients had a right to confidentiality, felt duty bound to respect this right and took actions designed to protect it. Earlier we saw how Xaria thought a patient's "rights as a person weren't being respected" (X454) when doctors failed to respond to the patient's request that she not be resuscitated if she had a cardio-respiratory arrest.

Nurses often referred to patients' rights when discussing the issue of disclosing information. That patients had rights to information was a commonly held view. We have seen how Gerri, for example, referred to the "right" of patients to be fully informed about proposed surgery including the possible risks involved. She based her reasoning on respecting patient autonomy and argued that full information was

necessary in order that patients were allowed "... their right to control or having a say in their own body" (G465). Similarly, we saw how Jane also thought, with respect to surgery, patients "... have a right to know exactly what they are going to have" and they have a "... right to know what they've agreed to" (J85).

Val also thought patients had "rights" to information. On the issue of the diagnosis of cancer, she thought doctors should not withhold information, and objected to the use of vague terms such as 'tumour'. In her reasoning Val applied the Golden Rule. She commented:

... if it was me and if I thought I had got cancer... and the doctor just told me that I had a tumour, if it was me I would ask and I would probably have a lot more questions ready if I got that far. I mean, if you had been through all the out-patients, all the scans, all the X-rays, biopsies, the lot, and the doctor still turns round and tells you that you've got a tumour and you still don't know what it is. I mean, you must know by then what it is. I think it is a patient's right to be told. (V659)

Tina also thought patients with cancer had a right to know their diagnosis and prognosis and that it was unfair to withhold such information. She also thought people were more aware of their rights than in the past. On the basis of respect for patient autonomy, she reasoned that it was important that people were informed in order that they were then able to make choices about their life and future. Tina explained:

... as I say, patients do want to know, they have a right to know, they know they have a right to know. And there are people who will be so grateful that they have been told so that they can make future plans and especially in this situation where, as I say, this lady will be dead within less than two years now I would imagine. And she will need to make plans for the rest of her family or help them make plans. And I don't think that is fair to withhold information... I think nowadays people are more aware of their rights and know they need to know and want to know and will actually go out of their way to find out more information now. (T382)

However, a respect for the rights of patients was not always the dominant consideration amongst nurses. We saw earlier how Kerri conceded to pressure from doctors not to inform patients and relatives about surgical mistakes made by them in theatre despite reasoning that they had a right to know and a right to officially

complain or take legal action if they chose to do so. Kerri thought, on the basis of beneficence, that it was best for patients to maintain a harmonious working relationship with doctors. Nevertheless, she commented:

And you kind of think they've got a right to know really. You know, it's us that made the mistake or it's a mistake that happened that maybe needn't have happened. And a lot of the time you think that you would actually rather people knew. Yea, ok, they may then want to put in an official complaint or sue or whatever but that's their right too. (K124)

Summary

To summarise this part of the chapter, the ethical reasoning and decision-making of nurses was complex and contained within it elements from different dominant and alternative theoretical frameworks. The main focus and influencing factor was their relationship with patients. The relationship-based nature of their thinking, along with other factors, was reminiscent of ethic of care approach, and indicative of partialist rather than impartialist thinking. The principles of beneficence and non-maleficence were important, and represented the use of teleological thinking, which was often directed towards the interests of individual patients. In this respect such thinking differed from utilitarianism with its emphasis on general welfare.

Nurses had a close professional relationship with patients and became emotionally involved. As a consequence they were liable to experience both emotional distress and reward. Emotional rewards served as a motivational influence in difficult circumstances for nurses, though the possible dangers of emotional involvement were noted and a degree of professional detachment was considered important in order to be able to continue to care. Nurses also sought empathetic insight into the experience of patients and recognised their feelings of vulnerability. Linked with seeking empathetic insight into the experience of patients, nurses applied the Golden Rule or the Golden Rule by Proxy. It was a helpful process in setting both ethical and clinical standards of care. However, the process had its difficulties as the values and preferences of nurses might differ from those of patients.

The ethical reasoning and decision-making of nurses was also influenced by the notion of a duty of care. While this represented deontological thinking, it differed from traditional Kantian deontology in that it was partialist in nature. Having a duty of care was inherent in the professional role, and implied, in particular, that nurses thought they had a duty as advocate to speak up or act on behalf of patients.

The ethical reasoning and decision-making of nurses was also influenced by a number of patient-centred ethical concerns. Truthfulness and trust were identified as important factors in the nurse-patient relationship. Having a concern for patient autonomy and agreement represented a wish to respect patient choice and led nurses to act in such a way as to facilitate it, though there were rare examples where paternalistic intervention might be justified. Being concerned that patients were treated fairly represented an interest in justice and a wish to ensure they were treated justly. A concern for patient confidentiality, based on respect for autonomy, led nurses to ensure patient information was protected. Nurses thought patients had a right to choose what information about themselves should be divulged and to whom. Having a concern for patients' rights implied nurses had certain corresponding duties and was therefore a directive for certain actions.

THE IMPORTANCE OF CHARACTER AND VIRTUES, AND THE ROLE OF CONSCIENCE AND GUILT

Nurses often referred to features of character, and personal qualities, they thought desirable and important in their ethical reasoning and decision-making. This was suggestive of Aristotelian virtue theory, and I will henceforth refer to such features as virtues. Nurses spoke of a number of different virtues that may be seen in Aristotelian terms as either intellectual or moral in nature. This indicates that their ethical reasoning and decision-making was influenced not only by action-based reasoning, but also by concern for the nature of being.

The purpose of this part of the chapter is to examine character and virtues important to the ethical reasoning and decision-making of nurses. Virtues identified by nurses as desirable because they contributed to the efficient functioning of the nursing team will

be examined, as will those nurses thought valuable in their ethical reasoning and decision-making. Finally, the role of conscience and guilt will be explored.

Virtues valuable to the nursing team

Nurses perceived nursing as a team activity where the capacity to deliver effective patient care was enhanced by team effort. Having the character and virtues necessary to be a good team member were desirable and valued. The day to day management of patient care was organised in nursing teams where each team was allocated specific patients to care for. There existed a strong nursing team ethos that extended to all parts of the nursing experience. Whilst nurses often faced ethical situations alone and had to make ethical decisions in isolation, they also often faced ethical situations together. In such circumstances ethical reasoning and decision-making was to some extent a collective process shared within the team. Nurses valued the opportunity of being able to seek ethical advice from others and this was an important aspect of their ethical reasoning and decision-making. It was important for them to be able to seek advice and deal with ethical difficulties within the team. A number of nurses referred to this. Lucy, for example, thought it important to be able to seek ethical advice from nurses and other professionals. She thought inter-professional relations on the ward had improved and different professionals were working as a team. Lucy explained:

... any ethical issue occurring... I would automatically, if I don't feel able to deal with it myself or take any decisions myself... go to the senior house officer, sisters on the ward, etc, and ask for advice... The ward has completely changed around. It's so much more working as a team at the moment... (L396)

Continuing, Lucy emphasised the importance of seeking advice in order to deal with ethical issues and to share the burden. She advised:

... at the end of the day I think the most important is, if you are not sure how to deal with a situation that you do go and see someone else and get advice... And that you don't... take the decision all on your own. Because, then the burden that you carry on your shoulders might be heavier... if you haven't consulted with anyone else. (L650)

Xaria, as a new and relatively inexperienced nurse also emphasised the importance of being able to seek advice, and the importance of teamwork in making decisions and achieving nursing goals. She discussed how she made decisions and explained:

... when it comes to looking after my patients I won't make snap decisions... If I have any doubt whatsoever I'll ask and then whatever has been told to me I'll then think... "Is this right?"...I think it is important that there is someone there. Not a separate person, even if it is your team or whoever, or another nurse. At least you have discussed it... A lot of it is experience with me. And especially team work, I think come what may if you are working with patients and it's their lives, their health, their rights... I think that you should work as a team. If you don't... it's not going to work... You are just not going to reach that target at all. I mean, you are thinking just totally different things. It is really important. (X561)

Being a good team member was a desirable virtue for nurses on the ward, but the existence of an effective nursing team was largely dependent on the example set by senior nurses in adopting a supportive style of management. Nurses identified several virtues required of senior nurses in order to do this. Four virtues were often referred to. Though closely interrelated, they may be identified as, being approachable, being supportive, being encouraging to others, and being a good role model.

Being approachable

Nurses thought senior nurses should be approachable. Mackay (1989:108) also found nurses thought the most valuable attribute of sisters/charge nurses was "being approachable". In this study many nurses referred to this virtue. Jane, for example, as a ward sister, thought it was important to be approachable in order that people felt able to raise things they found upsetting with her. She also thought it important to be flexible, to be supportive by taking on some of the day to day nursing duties when the ward was busy, and to offer practical help to nurses on the ward. She explained:

... I just think that you need to be approachable and that people should be able to come to you and tell you what is upsetting them... Also you should be flexible, you should be able to help them. Like, if I come on duty, even if I am co-ordinating and am in charge of the ward, and I see that the ward is busy, I do take patients. Like I say, I'll take the four-bedder. And Hilary does the same and Rebecca does the same... And that

would ease the workload... if they've got dressings or whatever, we help... Although sometimes it could be a bit more stressful for us having to take patients and still run the ward and give information, take telephone calls... Because... you could be on the phone for half an hour talking to a relative, or an ex-patient who wants some advice... That takes up your time. Sometimes I am trying to look after a couple of patients and the phone never stops and you think to yourself, "O my God, when am I going to do this... for this patient..." (J502)

Hilary, as a sister, also referred to the need to be approachable. She thought nurses tended to talk to each other and were reluctant to raise problems with her because she was the sister and they found that intimidating. Hilary tried to overcome this and to maintain her approachability by regularly asking nurses if they were all right. She explained:

... most of my staff, if they've got something that they want to say to me, they say, "Can I have a word with you?" And come and ask me or tell me. Or I'm always saying to them during the day... "How are you getting on with your workload, are you alright, do you want any help?" And I think most of them... tell me if there is a problem. But I do think they talk to each other more. Sometimes I hear things via, say, the ward-clerk because they will talk to him... and he'll come and tell me. Because I think having a blue dress could be slightly intimidating to some of the staff. Or, they've got a problem and they want to moan about it and they are not sure whether they want to moan about it to me or not. And they moan about it to somebody else. But, I don't put a sign up saying, "If anyone has got any problems, feel free to tap me on the shoulder and talk about it privately"... I just try and give the impression that I'm approachable and they can come and talk to me if there is a problem. And I will try to do something about it... I think they must get sick of me. I keep saying, "Are you alright down there, are you alright that end, do you need any help down that end." And then I go to the other end and say the same. So I just hope that they will come. And you can only do so much to get people to come to talk to you if there is a problem. (H433&458)

Winny, speaking as a sister, also thought managers should be "approachable" and "supportive" in order to encourage more junior nurses to seek support and advice. In addition she thought she should be knowledgeable and experienced and serve as a "resource for people" (W511). Ursula, also a sister, made similar comments. She thought it important to be, "... willing to listen to your staff, always being able to help them out with problems... And being able to show that you care for your staff and so hopefully they return that and if they do have problems they will come to you" (U433).

Lucy also thought senior nurses should be approachable. In addition, in order that they were able to help with difficult ethical situations, she thought they should be knowledgeable, trustworthy, respectful and respected. Lucy explained:

... [it is helpful]... if the nurse and the sister herself are approachable. If you know they've got a good knowledge base themselves, so that you know you can go and ask them, whatever answer that you get you know it is the right answer. But even if they don't give you the right answer... they would be trustworthy, and say to you, "Ok, I don't know that, but I'll find out for you"... I think they need to show some respect, they also need to gain some respect... I think a sister... will have to tell you as well when you are wrong... They will have to every so often tell you, "Hang on a minute, why are you doing this?" But as long as they do it in a good manner and don't kind of crack down on you and make you feel as if everything you do is wrong. Because the more wrong you do and the more you get blamed for things the less likely you are to bring things up. But if it is dealt with in a nice manner in the sense that they take you aside and ask you and question you why did you do this and have you thought about it, what if you did do it like this instead of like that. (L268)

Lucy thought it important that senior nurses had knowledge and were willing to support new and inexperienced nurses by sharing such knowledge with them. She also emphasised the need for senior nurses to have good communication skills, and thought the way sisters communicated with nurses set the tone for the way in which nurses then communicated with patients. Lucy explained:

... for us, anyone who is new on the ward, knowledge is quite important because the person you usually go to for the knowledge, if they can help you and supply you with that knowledge, tell you where to go, what to do, the best things to do to gain the knowledge you want to gain, you know, that is such a support as well. You know, obviously attitudes and things like that are very important as well. I mean, if you can't communicate properly with your patients and make them feel secure with you, you know, happy with what you are doing and happy to communicate any worries or anxieties then you are not reaching very far anyhow. And that is the same with the sisters as well. You know, if they are not communicating across to you and allowing you to express any anxieties, etc, then the same relationship is going to happen there as between the nurse and the patient. (L377)

Being supportive

Nurses thought the virtue of being supportive was important. This virtue was particularly important amongst peers. Often it was to their peers that nurses would turn first for support and advice. Gerri, for example, pointed out that, "The first thing I'd do is to discuss it with people in my own group, I think, and see what they would do, see what their advice is and get their opinion. If I couldn't... work it out in my head, then I think I would then go to somebody senior" (G632). Senior nurses tended to recognise this and would make efforts to facilitate the process. Hilary, for example, would send nurses to coffee in order that they could talk among themselves following their involvement in stressful incidents like resuscitation.

Kerry also referred to the importance of peer support. However, as a sister she was often on her own with no one to consult for advice. Kerry would take the opportunity to talk to the nurse in charge on the next shift during the shift changeover, or sought advice from sisters on other wards. She explained:

... if ever I've been in a situation where I've been faced with a difficult decision, I think peer support is really important...being a ward sister, the vast majority of the time you were the only ward sister on duty. So there wouldn't necessarily be someone there to discuss things with. And hopefully it was a situation where, if it didn't need an imminent decision, at least during cross-over time you've got time to sit and talk about things. Anything that needed immediate action was always going to be a problem... So, unless there was someone on another ward that you felt you could discuss things with, you really were on your own. (K587)

Hilary, like Kerry, also thought that as a sister there were fewer people for her to talk to. For Hilary, support from her family was important. She explained:

I have got senior nurses that I could discuss things with... I tend not to. I mean, staffing levels I discuss till the cows come home. They are completely sick of me... I bring it up every opportunity... because if anything happens I don't want them to turn round and say to me, "O, I didn't know anything about that." But things like arrests... if I feel it hasn't gone well... because I'm the same as the staff, you know, I think, "I should have done this, I should have done that, perhaps it would have been better." Usually it dwells on my mind for a while. Probably till I've slept on it. And even then perhaps it does... But I must say... there aren't as many people for me to talk to as I think the staff can... they talk to

their peers in the nurses' home... I might talk about some things in general terms... [to my husband]... but he's not all that interested really. I say, "I've had a bad day." And he says, "O well, I've got a bottle of wine in the fridge." (laughter) (H579&597)

Nurses felt that the ability to be able to support each other was important because it created an opportunity to offload their difficulties. Winny, for example, as one of the ward sisters, referred to the way in which discussing problems helps put them into perspective. She thought nurses got support from both senior nurses and their peers. Winny explained:

... I have certainly had nursing staff come to me if there... has been a difficult situation... to speak to me about it. It's always being able to talk to somebody, talk it through. It always seems to be what started off to be a problem, when you talk it through at the end of it may not seem such a problem... I think... they get their support as well, from their colleagues in their coffee break or their lunch break and I think it is probably good to talk about some things. To offload it and maybe offload it onto somebody else and talk about it. I think that is a support mechanism for them. With their colleagues as well as their manager. Sometimes they would be able to feel more comfortable, depending what it is, talking to their colleagues about something than perhaps coming to the ward manager. (W517)

Nurses thought it was important that they got on well and socialised. It was a good opportunity when socialising to talk about work and this was another useful way of offloading. Mandy, for example, explained, "... we go out on a night, just to the local. You have to, just to offload... It is [a useful thing to do]... definitely... you just offload and you have to. It's all you talk about, work... often we'll say, 'Look, stop talking about work.' But we always come round to it some way" (M650). Quincy also emphasised the importance of a "social scene" where "staff socialise a lot together so they do talk together a lot" (Q409). He also pointed out that it was important to have a good personal support network, "I've got quite a good support network with my friends and everything, we talk things over, get it out and then just move on" (Q352).

Nurses felt it was important on occasions to be able to withdraw from situations they found difficult and traumatic, and allowing nurses to do so was part of being a supportive senior nurse. Winny thought allowing nurses to take a break from stressful situations was part of being supportive. She thought "... allowing people to be able to

get away from situations” by going to their coffee or lunch break was helpful in allowing nurses to “refresh” before continuing (W483).

Lucy also thought there was a need for nurses to leave the ward for a period of time when faced with ethical difficulties. She thought that if the ward was busy and nurses became frustrated it was important not to take that frustration out on patients. If a nurse was unable to deal with the situation and there was a possibility that the nurse might take his or her frustration out on a patient it was important to get away and reflect. Lucy explained:

... if you do get frustrated at any time, I think it is... very important not to take that frustration out on the patient... because you will be frustrated. You have hundreds of things to remember...[and]... hundreds of tasks to do. And there is always little time on a busy ward like this. So I think always, always if you don't think you are going to be able to deal with a situation without taking your frustration out on a patient always get yourself off of the ward and clear your mind. And sit and just reflect back on the situation before you start dealing with anything. And make sure that you do the right thing... But sometimes it is very frustrating. I have found myself having to take a few minutes off the ward. But as long as you can get away from the situation, make sure that you don't take any frustration out on the patient I think is the most important. And take time to reflect and look back on the situation. (L672)

There is evidence from other studies to suggest that being supportive to colleagues is an important virtue. Åström et al. (1993) found that Swedish nurses felt team support by co-workers was an important source of support for them in ethically difficult situations. It helped enhanced nurses' sense of control, helped overcome the problem of nurses experiencing loneliness, and helped them care for patients. Additionally, Åström et al. (1995) found that Swedish nurses in oncology care identified that supportive co-workers who cared, who were prepared to listen, and with whom they could share their thoughts, helped them act according to their feelings and ethical reasoning.

Being encouraging to others

Nurses also spoke of the need for senior nurses to have the virtue of being encouraging to others. Hilary, for example, thought to give encouragement and praise

was an important aspect of supporting staff. She referred to stressful incidents such as when a patient had a cardiac arrest or died and outlined how she would support the nurses involved. She emphasised her responsibility to ensure nurses were all right, to offer the opportunity to talk about the incident and to allow nurses to get away from the situation so they can talk about the incident among themselves. She also emphasised the need to give encouragement and praise. Hilary explained:

... if we've had a particularly horrible arrest or someone has died, I try to speak to all the nurses involved and give them encouragement if they have had an active part in the resuscitation. They are quite junior mostly. I say, "How are you, are you all right? Would you like to go and sit down and have a cup of tea?" If we are short-staffed I'll send a couple of them that are involved... to coffee so they can talk together about it. Because I think it does help if you can get things off your chest to whoever. If they want to talk to me, I think they know that they can come and talk to me. And if there is a student there I say to them, you know, "Are you all right, is it your first arrest?" And I always say to them... "You did very well." Because in an arrest mostly, you just leap in there and you do what you've been trained to do. And it's very difficult to say, "Well, you should have done that or you shouldn't have done that." Usually the nurses are pushed out by the doctors as soon as the crash team arrive. I usually praise all the good things that they did during that arrest because I think it is quite frightening especially if the nurses haven't seen an arrest before. Or you always come out of an arrest feeling that you could have done more... So I usually try to praise them and say, "You did that really well, well done. And how do you feel now, are you alright?" If they want to sit down and talk about it, we've got rooms here where we can do that. (H383)

The issue of low staff morale has been referred to earlier. Hilary found that giving encouragement and praise was useful in improving morale amongst nurses. She explained how she would put all the 'thank you' cards from patients on a board in the ward corridor. Hilary also described how she would pass on to nurses positive remarks made by the hospital Chaplain who would come to the ward and talk to patients. Hilary explained:

... we have actually got a Chaplain who comes to this ward regularly. And she comes and she doesn't necessarily talk about religion, she'll talk to patients or staff. I mean, I've chatted to her in the corridor and she says, "How are things?" And I say, "O, it is dreadfully short-staffed, it's pretty awful." And now, every time she speaks to a patient and the patient praises the nursing staff, she comes and tells me. She says, "O, that lady over there has just said how wonderful you are and such a lot of

care you have given.” So, I tell the staff that as well. You know, it keeps morale up. Because I don’t think you actually get much praise to your face. I think you get complaints. But if the job is done well people don’t praise you, do they? It’s expected. And I try and do that with my staff as well. I always say, “Thank you” at the end of every shift. (H410)

Being a good role model

Nurses spoke of the importance of senior nurses being good role models. Nurses chose to emulate supportive senior nurses and the virtues they demonstrated. Rebecca, for example, explained how she learnt from the incident where she removed a patient’s chest drain and the patient subsequently developed a pneumothorax. She learnt who she would like to emulate. Rebecca spoke to Winny who was both objective and supportive. She explained:

... it helps you to choose the nurses that you would want to emulate, to be like, in that specifically I went to Winny and she went through the whole situation, very objective about it, but still offered me... not emotional support as such, but she actually didn’t tell me that I’d done wrong in that she said, “Yes, perhaps you should have done this, but not to worry about it, nothing has happened. You handled the situation fine. You did broach the subject and probably the... [nurse in charge]... should have intervened at an earlier stage.” And in that she was objective, it also gave me some support as well... So you pick up the people whose knowledge you can believe in, competence, you think that that person is more competent than the other. You know where you are going to go and get your teaching from. If there is something that you want to know, well I’ll ask this nurse, that sort of thing. Or, if something has gone wrong, well I’ll ask this nurse because they will be objective about it and will tell me if I’ve gone wrong anywhere but they won’t just be blasé and say, “Well you should have done this.” (R420)

Rebecca’s account is interesting because it highlights how a role model might help, in Aristotelian terms, to perfect both the intellectual and moral virtues. For Rebecca, the role model assisted, by instruction, in the perfection of intellectual virtues such as objectivity, practical wisdom, knowledge and competence, while at the same time also assisted, by demonstration and habit, in the perfection of moral virtues such as supportiveness and honest appraisal.

Virtues valuable in the ethical reasoning and decision-making of nurses

So far we have discussed how certain virtues identified by nurses were important in creating a positive management style and a supportive ward environment helpful in dealing with ethical difficulties. Nurses also spoke of virtues that were helpful in their ethical reasoning and decision-making. They identified a number of what were, in Aristotelian terms, intellectual and moral virtues. Virtues most frequently referred to included: courage and fortitude, experience and confidence, clinical skill and credibility, and being questioning and reflective.

Courage and fortitude

Nurses used terms such as “courage”, “strong-minded” and “strong” to describe traits of character they thought useful in dealing with ethical difficulties. I have classified such terms as representative of the virtues of courage and fortitude. The two virtues are similar and will be considered together.

Several nurses referred to these and related virtues. Tina, for example, thought that within a hierarchical system a nurse needed courage and confidence in order to deal with difficult ethical situations. She explained, “I think to be able to stand up and say what you believe as a nurse... takes a lot of confidence and a lot of courage... you really have to have the courage of your convictions to be able to go ahead and follow... [decisions]... through” (T223). Quincy reflected on his personal qualities and thought he was “strong-minded”. He felt this was a useful quality in ethical decision-making, particularly when combined with having experience (Q352). Ursula, as a ward sister, thought it was important when faced with difficult situations to be strong and to have a clear idea of what was required as a leader. She commented:

... I think basically if you're here in a leadership role then you have to have fairly clearly defined leadership because it is no good running around and... thinking in your own mind, “O I don't know what to do...” But when people are looking to you to be quite strong in a situation, you can't be... wishy-washy... (U600)

When nurses referred to leadership and leadership styles they often referred to terms such as “assertive”, “democratic” and “autocratic”. Such terms were used in a way that suggested they were linked with the virtues of courage and fortitude. Winny, for example, spoke of situations where nurses and doctors disagreed over the readiness of patients for discharge home following surgery. In such circumstances she thought it was difficult to challenge the decisions of doctors because they felt their judgement was being questioned. In order to do so, Winny thought she had to be assertive, democratic and on occasions autocratic (W647). Ursula thought it important to have a leadership style that was neither autocratic nor always democratic, but was flexible or “transitional” depending on the situation faced (U416).

Nurses faced many situations that required the virtues of courage and fortitude. Indeed, Winny thought simply being a nurse and accepting the professional role of the nurse required strength without which the nurse would not be able to care for patients. She commented:

... [acting]... in a professional manner... is not easy... It depends on the situation but it can be quite difficult... you know that at the end of your shift that you are able to leave your workplace... take off your uniform and... leave the situation behind you... You think about it, but it is not as if it's your relative, in terms that it is impinging on your personal life. I think within your professional... [role]... you have got to show... you are strong, because otherwise... you are not going to be of any use to anybody. (W457)

Experience and confidence

Nurses felt experience and confidence were important virtues when dealing with ethical difficulties. Lützén et al. (1997) found that the moral sensitivity of Swedish psychiatrists was developed by experience. Several nurses referred to these two virtues. Val, for example, thought it was harder to act in the best interests of patients if the nurse lacked confidence and experience. She recalled an incident when she was an inexperienced nurse and was unsure about the appropriateness of a patient's prescribed drug regime. She was faced with the decision of whether to administer the medications or not. Other nurses encouraged her to question the drug regime with

doctors. She did so, but eventually administered the medication because doctors insisted it was what they wanted for the patient. Val explained:

... it is... [difficult to follow doctor's orders]... if you think that what you are doing is not for the best interests of the patient really. And it makes it harder if you are not confident in your own role... Not that long ago... there was this situation where... this chap was very ill... he was septic... renally obviously he was impaired as well. He was already on a high dose of Dopamine and... [doctors]... wanted to give him high doses of Lasix. I mean, I'm not that experienced... and the other nurses were saying, "Don't you think that's a high dose... [and]... too much to give?" And the doctors were insisting that I should give it. I felt caught in between which way I should go. So one of the other nurses who was more experienced than me said... [I should]... challenge the doctor and say, "Is this really the way you want to go?" In the end I had to give the drug because they were insisting this is what we should do for the patient. (V64)

Winnie also discussed the importance of being experienced. She thought it was helpful in making decisions and nurses who were inexperienced sometimes faced difficulties. Winnie explained:

I do think that if you have got experience in an area I think it certainly does help when you are making a decision. The more experience you have, the more reflection you can do after an experience or a decision or whatever... A situation perhaps that maybe I would have had to deal with as a sister and the situation that I would have come across maybe as a junior staff nurse I can reflect and look and see how I would have dealt with it then and now. There is a difference because I have got experience. What I did then would not necessarily be wrong but I wouldn't have had the experience and the confidence that I have now. I think that is quite important... (W740)

Winnie continued by using the example of being short-staffed. In such circumstances nurses still wanted to give the best standard of care possible. It was necessary to prioritise in order to do so. For inexperienced junior staff this was sometimes difficult because, as Winnie explained, "They haven't got the experience to use these skills themselves, they are working as hard as they can and it can all become a little bit much at times" (W740).

Quincy also referred to the importance of being experienced, particularly when in charge of the ward. He thought that along with management and people skills, it was

an important and necessary quality before junior staff were promoted to higher positions. Quincy explained:

You can see how people cope with running the ward on a day to day basis with how much experience they've actually had... It's like a lot to do with junior staff and I think it is important that staff get a lot of experience before they actually end up in... more senior roles. I was five years qualified before I got my first 'F' grade. Whereas nowadays people seem to be moving up a hell of a lot quicker. And I don't know if it is a good thing. I don't think they've got the experience and the skills. You know, just the management skills let alone the people skills to actually deal with it. (Q384)

Inexperience and lack of confidence were particular problems for newly qualified nurses. Xaria referred to the difficulty of decision-making for the inexperienced nurse and the need for newly qualified nurses to "overcome that confidence barrier" (X47). Winny felt that junior nurses who lacked experience and confidence found it difficult to address other members of the multi-disciplinary team. She explained:

I think that people that are less experienced maybe some of the more junior staff nurses may not always have the confidence to address members of the multi-disciplinary team about issues which someone with a bit more experience might do. For instance on a ward-round a junior staff nurse may not... [question the doctor]... if she was concerned for example about a wound... and the doctor felt that it was ok... in that situation they may not always have the confidence or the experience... And it is not a bad thing. It is not a negative thing. It is something they are going to gain with experience. You have got to start off somewhere haven't you and gain your experience as you go along? (W721)

Rebecca's incident involving the removal of a patient's chest drain illustrated the difficulties of a junior nurse who was new to the clinical area and who lacked experience and confidence. Despite raising her doubts with doctors and the nurse in charge about the clinical wisdom of doing so, Rebecca was instructed to remove the patient's chest drain. As a consequence of her doing so, the patient developed a pneumothorax. Rebecca thought it was important that she had more confidence in her knowledge. When asked what she had learnt from the experience she replied:

To go on what I believed for myself. You are responsible for your own actions and to be a bit more confident in my own... knowledge and what I've read. And just because somebody is more senior than me doesn't

mean, you know, nobody can be a master of everything and maybe you have that little bit more knowledge in that area than the other person. (R272)

Clinical skill and credibility

Nurses thought being clinically skilful and credible were important virtues in ethical reasoning and decision-making. Lützén et al. (1995) in their study into the moral sensitivity of Swedish psychiatric and general medical-surgical nurses similarly found the Aristotelian notion of practical wisdom to be important. A number of nurses referred to these virtues. Ursula, for example, spoke of the need for nurses to be confident, strong, and clinically credible in order to effectively take part in multi-disciplinary teamwork. This was particularly necessary when dealing with cardiac surgeons, who Ursula thought appeared to be autocratic. Ursula explained:

... I think it is a lot to do with confidence and you have to build up a good rapport between teams. I think, being realistic, that cardiac surgeons are particularly difficult in the fact that... perhaps it is just the way they have been trained but they come out as very perhaps autocratic people. You have to be quite strong to have your opinions listened to and I think you have to be very clinically credible as well. I think then that people will listen to you... And I think as far as physios go and OT and speech therapists and people like that... [for them]... nursing is a very credible profession... and they do listen and want nurses to participate in multi-disciplinary teamwork. (U263)

Tina felt that the decision-making of nurses would be made easier the more nurses increased their clinical credibility and skills and developed specialist nursing roles. She explained:

I think... some of the roles... taken on by nurses, especially in nurse specialist role, will go a long way to assist nurses in making decisions. The way forward for many areas will be that nurse practitioners are employed and should therefore have a greater understanding in a specialist area. The sort of level that doctors would normally be. (T512)

Being questioning and reflective

Nurses also spoke of the need to have the virtues of being questioning and reflective in dealing with ethical difficulties. Ursula, for example, reflected on her past

experiences as a junior nurse on wards where medical research was taking place. She thought the research might have been inappropriate and felt she should have raised various questions but felt she was not “bolshi” enough to do so. Ursula explained:

... sometimes you kind of thought that the research was not appropriate... and perhaps the patient shouldn't have been on the trials... But then again I wasn't in a position to perhaps even fully understand what the research was about and I don't think at that time I was quite bolshie enough to stand up and say, “What is the research doing?” “What's the benefit to this patient?” “What are you going to learn from this?” “Ok if it is not benefiting this patient what are you hoping to learn?” And things like that. (U471)

As a ward sister now, Ursula emphasised the importance of having staff who were questioning. She explained, “The best that you can have is people that always question you about what you do and will question you about what the medical staff are doing... You want staff that look at things and think about things and ask you questions about it” (U434).

Rebecca thought she should have questioned the view of the nurse in charge more in the incident involving the removal of the patient's chest drain. She commented:

I think if I'd not accepted the... [nurse in charge's]... view of it straight away. If I had questioned... [and said,]... “Well I have read such and such and as the patient has got an air-leak if I take this out they're going to get a pneumothorax and will need another drain put in. Can you explain to me why in this case you don't think that's going to happen?” If I'd not accepted his word as quickly as I did at the risk of feeling silly... And even then, if he explained to me why this thing wouldn't have happened, I still wouldn't have believed it, I still wouldn't be happy to do it and would have to refuse and say, “Well I'm not happy to do this because I don't think it should be done.” Or, “You haven't convinced me it shouldn't be done, but if you are happy to take it out then...” (R322)

Being reflective was another virtue considered important by nurses. Zoe, for example, pointed out that nurses make many decisions during the day and are involved in a process of reflection in order to assess whether the right decision had been made. She commented:

Whether you have made the right decision regarding staff, patients, interaction with the doctors, as I say when you particularly get to my grade and beyond you are making decisions throughout the day and you often go home and think, “Well, was that the right one?” I think that’s part of the process when you do go home, this kind of reflective process. (Z43)

Ursula thought reflection was important in the process of personal development and the formation and acceptance of new ideas. She commented:

... I think if you have... been in nursing ten years and you haven’t formulated some opinions... what have you been doing? You haven’t been looking at past experiences... [and]... you haven’t been trying to learn from them... you can sometimes think, “O yes, well that’s a new situation and perhaps I could have dealt with it in that way”... I think that if you reflect a lot then it makes you open to new ideas and it means that you look at situations. (U617)

Nurses valued the virtue of being reflective and pointed to the benefits of nurses reflecting on their experiences. Rebecca, for example, reflected on the incident involving the removal of the patient’s chest drain and thought the process of doing so helped her learn from her mistakes. She commented, “... as I say, it has kept with me all the time and it’s served its purpose in that it has not happened again or it has probably stopped... me from doing something worse so to speak. It was a learning experience. It’s sort of, we all make mistakes at some stage” (R382).

Conscience and guilt

Conscience and guilt were also important in the ethical reasoning and decision-making of nurses. Both terms are closely related to character and virtues, as having a conscience and feeling guilty reflected the character and personal values of the nurse. Nurses spoke of their conscience or of having feelings of guilt when discussing difficult ethical situations they faced and how they dealt with them.

Conscience

Several nurses referred to the term “conscience” when discussing their ethical reasoning and decision-making. The term was used both as a means of moral

reflection and as a guide to ethical action. It was a strong directive to take actions considered to be right. Failure to follow one's conscience led to feelings of wrongdoing and guilt.

There exist differing interpretations of the term conscience in the literature. Beauchamp and Childress (2001:35-9) relate the term to the virtues of integrity and conscientiousness. They point out that it should not be viewed simply as a faculty of, or authority for, moral decision-making, but as a "... form of self-reflection on and judgement about whether one's acts are obligatory or prohibited, right or wrong, good or bad" (Beauchamp and Childress, 2001:38). It may also be seen in terms of an internal moral sanction that often appears as a bad conscience when the individual might experience feelings of remorse, shame and guilt, upon realising that an action was wrong. This form of conscience is likely to occur in people of strong moral character (Beauchamp and Childress, 2001:38).

Johnstone (1999:395) surveys the philosophical literature and describes three accounts of conscience, either as moral reasoning, or as moral feelings, or as a combination of moral reasoning and moral feelings. She finds the third account the most plausible as it does not rely on "blind emotive obedience" nor "blind devotion to reason", but is guided by "moral sensibilities and moral reasoning" (Johnstone, 1999:396).

Two nurses in particular spoke of their conscience and the role it played in determining their actions. The first was Yvonne who, as a sister, referred to her conscience when dealing with a nurse colleague who felt suicidal. Yvonne found herself in a difficult position after the nurse had told her, in a "private discussion", that she was "suicidal and being treated for clinical depression." Yvonne described this as one of the most difficult situations she had been involved in. She felt she was dealing with someone's life and career and she was very concerned about the mental state of the nurse and the possibility that she may do herself harm. Yvonne's conscience dictated that she breach confidentiality and report the conversation to the head nurse. Yvonne did not feel guilty for taking this action as she felt it was the right thing to do. She explained:

... I was then left with a very difficult decision because she actually very aggressively told me that the conversation was confidential and that I should not disclose it to anybody. And... I couldn't do that... my conscience told me that I couldn't allow... [her]... to come to work feeling as unwell as she was. And so I had to actually take it further and go to my head nurse and... [the nurse]... was actually formally suspended on medical grounds and probable won't come back here. I think that's one of the most difficult things that I have ever been involved in at work. I think simply because it was very much dealing with someone's life and I felt very much that she was on the knife's edge of life. I was very, very concerned that she might actually do something when she went home that night after she was suspended. She didn't, but it was hard, it was really, really hard. And I still think about it now. I still think that her career has possibly been damaged for good because of this. You know. I'm not saying that I feel guilty about that, because I don't. I still think that I did the right thing, and I still think that I would do the same thing again but it's, you know, it's someone's career, it's someone's life. (Y90)

Yvonne continued by saying that, guided by her conscience, her actions were motivated by her concern that the nurse or patients might be harmed. She explained:

... my conscience told me that if she carried on working something would happen either to her or to a patient. And I just felt that she wasn't coping at work. A number of things had happened in the week prior to this where she physically looked drained, she looked dazed. I thought then that perhaps she'd been taking anti-depressants or something like that. She looked sort of very sedated sometimes and she is in fact on medication for clinical depression. And I didn't feel at the end of the day that it was safe for her or for the patients for her to be at work. That was the underlying problem with it really. I think that was the final decision-making kind of, that was what made me take those channels. (Y109)

Xaria also referred to her "conscience". As an inexperienced newly qualified nurse she was troubled by her conscience when she forgot to perform certain nursing tasks. Xaria explained:

There were times when I had actually forgotten... [I'm]... being honest now, forgotten to do blood pressures and things... when I stopped and looked at my own work... I thought, "Well should I have done it or shouldn't I? Should I have done it because it should have been done at 11 o'clock or was it ok because I felt happy that my patient was ok?" And... I was busy doing other things. That really used to bug my conscience. Whether that was the right thing to do or not. (X53)

As with Yvonne, Xaria's conscience appears to have been motivated by concern for the principle of non-maleficence. She continued by saying that her conscience was troubled by the thought that her actions may adversely affect her patient. She was also confused by different expectations of her on the ward at different times. Xaria explained:

... at times the ward was... task orientated... You do this, you do this, you do this. But other times... you could leave... [things]... till later if you wanted to. I think it depended on how busy the ward was. They'd like everything done or if there was enough time you could space out your work. So, it was shall I or shan't I... do it now?... Whether it would affect my patient... that was what was... on my conscience... Is the patient well enough that he could have missed that blood pressure or was his physical state unstable? Should I have done it?... Because it is cardiac, I know now... looking in hindsight...[my patient]... could have gone into different rhythms, pulse could have increased, could have been internal bleeding... it could have been many things. At the time it wasn't that kind of thinking. (X64)

Xaria continued by pointing out that, as she became more experienced she became better at assessing patients, prioritising her care, and making decisions. She explained:

... the way I work with patients now is totally different to when I first went on the ward and I fully assess everything about the patient, CVS, respiratory, drains, etc. as soon as I come on. Then I prioritise a lot better than I did initially... Then if I feel that he... or she is stable enough and the patient is resting or whatever then I won't disturb them just to do a blood pressure or to take a pulse... I mean, it really depends. My assessment initially and prioritising my work has improved from when I first came on the ward. (X107)

Guilt

Nurses often referred to their feeling of guilt when they discussed their experiences in dealing with difficult ethical situations. Relatively little attention appears to be given to the emotion of guilt in the theoretical literature. However, the existence of this emotion in nurses in this study may be explained in a number of ways.

We have seen how oppressive environmental features led to what appeared to be a culture of blame, and how nurses were sometimes unjustly blamed. It appears that in

situations experienced as oppressive, sensations of guilt might occur as a form of defence. For example, Rebecca was unjustly blamed over the incident involving the removal of a patient's chest drain, yet her response was to feel "awfully guilty" (R379). Gibbard (1990:297-8) argues that having feelings of guilt is a mechanism of anticipating and therefore placating the anger of others at our faults. Also, the connection between blame and feelings of guilt might be explained by the close relationship of the terms 'guilt' and 'culpability', as the latter has its origins in the Latin *culpa*, meaning 'blame' (The Concise Oxford Dictionary, 1995). Hence, Rebecca, like a number of nurses, spoke of her feelings of guilt in the context of blame.

It was evident that nurses referred to the emotion of guilt in relation to an assessment of the morality of their actions. Thus when they felt their actions were compatible with their obligations to others they did not feel guilty. We have just seen, for example, how Yvonne said she did not feel guilty because she thought she did the right thing in breaching confidentiality when faced with a colleague who felt suicidal. Gibbard (1990:298-300) suggests that guilt and anger when governed by moral norms could positively influence actions and thereby help regulate social life.

On the other hand, it was common for nurses to express feelings of guilt when they felt their actions were not consistent with their obligations to others. There were many examples of guilt being expressed in this way. We have just seen, in the chest drain incident, how Rebecca felt guilty because she did something she "felt was wrong" (R239). In fact, Rebecca continued by pointing out that she also felt guilty when she witnessed how patients suffered as a result of the decisions of others, as for example, in the case of late cancellation of a patient's surgery. She pointed out that it was the nurse who was usually present who had to deal with the situation and the patient's reaction. She commented, "It's like so many people make the decision to cancel surgery, so many people make the decision to remove drains, you're the one that's actually there, you're the one that feels guilty, and you're the one that gets the reaction to that as well" (R457).

We have also seen in the previous chapter how Hilary thought nurses felt guilty because they were busy and unable to give the care they would have liked to two

patients with tracheostomies. In fact, Hilary raised the issue of guilt on a number of occasions. She discussed how nurses experienced feelings of guilt when they were unable to give the high standard of care they were trained to give. Hilary explained:

I think most nurses... they are not all perfectionists, but they aim quite high with their care. I mean, you think of the patient as, "This could be my mother or my father or a relative." And you know how you'd want them to be treated... [Nurses]... have had three years training. They've had a good training. They are taught to achieve high standards of care. And I think if you fall below that standard, you do feel guilty. Some feel guilty. I feel guilty. If I know that someone hasn't had their stockings changed for three days I'm embarrassed... and I'm saying, "I'm terribly sorry, let's change them now"... And most nurses are the same. They care, I think, otherwise they wouldn't be in nursing. And it's frustrating if you get to the end of the day and you go home and you think, "Well, I haven't done this, I haven't done that, I haven't done the other thing." It's frustrating, isn't it? When you feel you've left it for someone else who is going to be just as busy or it won't get done. (H171)

It is notable that Hilary used the Golden Rule by Proxy as a yardstick for determining appropriate standards of care. She also referred to the often-mentioned "frustration" of nurses. Hilary refers to the frustration nurses experienced when their efforts to maintain the high standards of care they were trained to give, to complete the care required, or to finish the necessary tasks during their span of duty, were made difficult by heavy workloads.

This use of guilt by nurses in association with the degree to which they felt they had fulfilled their obligations to others may be explained by the theory of reciprocity. In this respect Hilary's application of the Golden Rule by Proxy, which is based on the notion of reciprocity, is significant. Trivers (1994:86) discusses the evolution of reciprocal altruism and suggests that the emotion of guilt has evolved in humans in order to motivate the "cheater" to acts of compensation for misdeeds, to behave reciprocally in the future, and therefore to prevent the rupture of reciprocal relationships.

Summary

To summarise, this part of the chapter outlines the importance of character and virtues, and the role of conscience and guilt to the ethical reasoning and decision-making of nurses. The identification of such factors as important is suggestive of Aristotelian virtue theory. Nurses referred to many virtues important in their ethical reasoning and decision-making. Virtues were separated into two groups. The first contained those important to team nursing, and thereby contributed to the effective provision of patient care and the collective resolution of ethical difficulties. The second group includes virtues that were helpful to nurses in their ethical reasoning and decision-making.

This part of the chapter also considered the role of conscience and guilt in the ethical reasoning and decision-making of nurses. These were important factors and were influenced by the character and personal values of nurses. Nurses used their 'conscience' as a means of moral reflection and as a guide to ethical action. It influenced nurses to take actions they considered were right and they experienced feelings of wrongdoing and guilt if they failed to follow the dictates of their conscience. The emotion of guilt was closely linked to the experience of blame felt by nurses in the context of an oppressive culture. Guilt was also related to the degree to which nurses felt their actions fulfilled their obligations to others, and may be explained by the theory of reciprocity.

CHAPTER CONCLUSION

To conclude, the ethical reasoning and decision-making of nurses was complex and included in it features from both the dominant and alternative theoretical frameworks identified in chapter one. Styles of thinking representative of dominant theoretical frameworks including teleology, deontology, rights theory and the application of principles such as beneficence, non-maleficence, respect for autonomy, and justice, were all in evidence. There existed also evidence that ideas from alternative theoretical frameworks were also important. In particular, the ethical reasoning and decision-making of nurses was partialist in nature, with their relationship with the patient at its heart. This, coupled with emotional involvement and the use of empathy,

was indicative of the ethic of care. Additionally, the identification of virtues important in the ethical reasoning and decision-making of nurses was suggestive of virtue theory, and highlighted the importance not only of action-based theory, but also of theory related to the nature of being.

In this and the preceding two chapters I have discussed the findings of this study that resulted from the coding analysis of the data. In the following chapter I will present findings that resulted from the narrative analysis of the data.

CHAPTER SIX

NARRATIVE ANALYSIS

This chapter presents findings resulting from the narrative analysis of a selection of the data. The method of narrative analysis used was that of “poetic representation” (Richardson, 2000:933). This method of analysis as well as other methodological details is discussed in full in chapter two. I would, at this point, like to stress that the analytical process by which the prose of interview transcripts was transformed into poetic representations was one used to clarify and elucidate the ethical reasoning and decision-making of nurses. The reader is therefore encouraged to view the poetic representations, in themselves, as products of the analysis. I have selected three examples of narrative and have presented them in a poetic format. Each example depicts an incident that has been referred to in the coding analysis of previous chapters. A discussion will follow each narrative.

GERRI'S NARRATIVE – doctors would not write a DNAR order on a dying woman

There seems to be
an unwritten policy
on here
by the doctors,
they won't put anybody,
'not for resus,'
ever.
It doesn't matter what's wrong with them,
what kind of state they're in.
They won't admit defeat.
There was one particular incident where
the nurses were basically pleading
with the doctors
to put a lady 'not for resus'
because she was in terminal stages of cancer.
Her body was all swollen up,
she was delirious,

we couldn't assess how much pain she was in,
although she was getting painkillers.
She was really in a terrible state,
with only hours to live.
And she was still for resus.
So we knew that if she passed away
that would be it,
we'd have to
do all the procedure,
resus and call the team out
and all the rest of it.
Jump all over this poor woman
and for what?
To bring her back
to last another couple of hours maybe.
And we were on and on at them all day.
And there was one point where she actually started to go.
And she was attached to a heart monitor
and we were watching her pulse.
It started off at about sixty-odd
and it went all the way down to twenty.
And there was me
and another staff nurse
and we just stood there
and we knew that she was for resus.
And I know
we were both thinking the same thing,
"Well, what are we going to do if it stops?"
It was quite difficult.
But luckily we never had to decide
what we would have done
because it went back up.
But the situation got worse
Because our doctors
then decided
they couldn't deal with this women
and they transferred her
to the cancer ward.
Which like,
she'd been with us for months and months,
weeks, you know,
she'd always expressed a wish
to stay with us.
And you can't tell,
she was delirious,
how much she knew about where she was
and they wanted to
just
dump her off
on some other ward.

So the whole thing
was a bit of an ethical nightmare.

She wasn't for 'not for resus'
and we knew this.
And
we stood there
watching this heart monitor
and we had to make the decision,
were we going to act.
And maybe,
we would have to do it,
but you know,
would you,
kind of,
be slow about it
to make sure it was far too late?
That was the first part of it.
And the second part of it,
we should have put our foot down
and demanded
she wasn't moved to the other ward.
That she died in peace
in the one place
and wasn't just carted off
to some place
and dumped somewhere else.

[She died] an hour after she was transferred.
It was just
really awful.

[I feel she should not have been resuscitated]
because basically
we didn't know
whether she could have been in a lot pain
which we couldn't help her with
and she was having
all the pain killing drugs she could have.
She was agitated
and if she had been resuscitated
she would have been on life support
and she would have had
no quality of life whatsoever.
And there was no hope for her.
There was no cure.
There was no palliative treatment she could have.
She was past all help.
[Intervention would mean her death would have]
completely no dignity and no peace.

It is just my personal theory,
but [doctors] just won't admit to defeat.
They are very tunnel-visioned.
They have their body
and they cut it up
and they expect them to go out of here.
Either walk out
or get wheeled out or whatever.
Just go out of here
and they have done their job.
So when they get somebody
that's got problems
they can't deal with,
that is beyond help,
then they don't know what to do,
they get all confused.
And they don't want to admit
they can't do anything.
On the other hand
it could be just pure laziness.
Lack of willingness
because to put somebody 'not for resus'
you've got to speak with the family
and do all this kind of thing,
it could just be
they didn't want to deal with all that.

She'd been on the ward for,
it must have been about four weeks.
[There was not a legal requirement
to resuscitate her.]
She went down hill very fast,
but she had been on the ward
for about four to six weeks.

Both of us staff nurses
had looked after her
for those six weeks
and had got to know her
and had been there
when she was saying,
"O, I don't want to leave this ward.
I don't want to go to another ward."
This was when she was still
fully functioning mentally.
So we had been through all that
and we knew what this woman wanted.
So, yea,
I think doctors

are definitely looking at it differently.

At the same time
they are more objective than we are.
Because they could say
we are too
emotionally involved
to make rational objective decisions.
[I did not feel
I was too emotionally involved
to make a rational objective decision].
There is nothing wrong
with [being emotionally involved].

I think I was quite angry.
Angry and frustrated.
Because it showed
the lack of control
we had over the situation.
Because normally you go along quite happily thinking
you're in charge
and can sort it all out
and this shows
there is times when
it doesn't matter how hard you try
you just can't.
You just have to go with the flow.

We were saying to the sister
who was on at the time.
There were the three of us,
me and the other staff nurse and the sister.
We were all trying to get these doctors
to sort it out.
So we all,
and afterwards as well,
me and this other staff nurse,
we had a good old,
debriefing about it
and a moan
and all the rest of it.

I don't think [doctors knew
how we felt] really, no.

I don't think the sister portrayed our views.
She was just
spelling it out to them,
"Look at this women."
And she got them down there

to see her.
Got that far.
“Look at this women,
she has no quality of life.”
“We need to put her ‘not for resus’
it’s not fair on [her].”
But doctors,
I feel are
very touchy about that.
They seem to take
nurse requests personally.
They have this mentality
that any request a nurse makes,
you know,
if I asked a doctor for a painkiller,
you have to say,
“Will you do
me a favour?”
And it is not doing
me a favour.
I’m not in pain.
It’s the person.
I’m just trying to get a job done.
I’m a mediator.
It’s not for me.

It’s a kind of cultural thing.
Everybody does it.
And all the doctors take it personally.
If you want them,
“Will you do me a favour,
will you put this venflon in?”
And they are like,
“O no, I don’t really want to do it.”
“Well,
you know,
it’s not for me.
I’m not asking you for the fun of it
so that I can see you all annoyed,
it’s for the
patient.”
So, I think you tend not to bother telling them,
“Will you put this women
‘not for resus’
because we are going
to have to leap all over her
and we know her
and we feel sorry for her.”
Because that will get you absolutely
nowhere.

As soon as she got to the other ward
where they are used to dealing
with people
that have gone beyond our help
she was
immediately put
'not for resuscitation'.

[Presumably she died peacefully]
but
still amongst people
she didn't know
in a place she had never been to.

[It was helpful talking about it
with someone who felt the same]
I mean,
it is always good to share
your moans and your problems.
I think it was good as well,
it made you feel better
that you weren't the only one
standing there thinking,
"I don't want to do this.
If this women's heart stopped beating
I don't want to do this intervention."
It's good to know
that you wouldn't have been
the only one saying,
"Slow down a bit."

[We were relieved
when her heart rate increased.]
Yea, yea.
And we weren't the only ones.
There was two students as well.
And because the woman was so agitated
we needed somebody with her constantly,
and they had been holding her hand
and talking to her,
so it was quite traumatic for them as well.

I'd say they were both very shocked.
And I think they were both quite confused.
I remember they asked a lot of questions afterwards
and that sort of thing.
They were talking about it
a good week or so afterwards.

Me and the other staff nurse
went through it
and any questions they asked,
we were there
and kept them informed
when she eventually
went off to the other ward.
Yea,
I think they were quite well supported.
(G47-274)

Commentary

The ethical incident

Gerri's narrative describes an incident where nurses were expected, in the absence of a DNAR order, to attempt to resuscitate a terminally ill and dying cancer patient if she had a cardiac arrest. At one stage the patient's clinical signs indicated her heart was close to stopping. In the event her heart rate increased and she did not have a cardiac arrest. Gerri was not alone in her experience of the incident. It was also witnessed by a nurse colleague and two student nurses. Professional and power relations with doctors, and the hierarchical way in which decisions were made appear to be central to this ethical situation faced by nurses. Gerri thought there was an "unwritten policy" that doctors did not write DNAR orders on terminally ill patients on the cardio-thoracic ward. Despite nurses "pleading" with doctors to write a DNAR order on the patient, they refused to do so. The situation worsened when doctors decided to transfer the dying patient to another ward. Gerri describes the whole incident as an "ethical nightmare". Gerri's ethical choices concerned what action to take if the patient arrested, and how she ought to respond to the doctors' decision to transfer the patient.

Gerri's ethical reasoning and decision-making

Gerri's ethical reasoning contains several features representative of the ethic of care approach. It has at its heart her close relationship with the patient. In addition, Gerri refers to her emotional involvement. Interestingly she thought there was nothing wrong with being emotionally involved and that it did not prevent rational decision-

making. Furthermore, with the patient at the centre of her considerations, Gerri was concerned that her actions were in the patient's best interests and not harmful to her. She thought the patient had no quality of life, that there was no "hope" for her, "no cure", no available palliative treatment, and that she was "past all help". To resuscitate her, Gerri reasoned, would prolong a painful life and would mean a death without "dignity" or "peace". In the absence of a DNAR order Gerri thought she and other nurses would have to commence resuscitation, but considered the possibility of resisting by wondering whether they "... would be slow about it to make sure it was far too late?"

Gerry also thought it was important to respect the patient's wishes. Gerri had cared for the patient for some time and knew she wished to remain on the ward. Gerri thought it disrespected the patient's autonomy to transfer her to another ward, in addition to being against her best interests and indeed harmful. Gerri advocated resistance and thought nurses "... should have put their foot down and demanded she wasn't moved to the other ward."

Much of Gerri's narrative concerns her perceptions of professional differences and relations between nurses and doctors. Her perceptions in this respect influenced her ethical reasoning and actions. Gerri thought doctors, unlike nurses, remained emotionally detached in their relations with patients. She felt such was the difference between nurses and doctors in this respect that nurses tended not to inform doctors of their emotional involvement with patients, as they thought doctors would not understand. Gerri believed doctors were unaware how nurses felt over the incident. She thought doctors had a different perception of patients, in that they adopted a bio-medical view where "... they have their body and they cut it up and they expect them to go out of here." Gerri thought there were several possible reasons why doctors were reluctant to write a DNAR order, including laziness, an unwillingness to admit defeat, and not knowing what to do when the patient was beyond help.

Gerri's narrative includes interesting insights into her perception of the hierarchical nature of professional relations between nurses and doctors, and the process of decision-making. She thought it was difficult for nurses to ask doctors to do things, in this case to write a DNAR order and not to transfer the patient to another ward, as

they were “touchy” about nurse requests and took them personally. Gerri describes how, as a result, nurses had to comply with the “cultural” ritual of asking doctors to “do them a favour”. Of course, the favour was not for the nurse. The request was for the doctor to do something for a patient. In fact, this interaction is reminiscent of the observations made by Stein (1978:107) in “the doctor – nurse game”. In the “game” the nurse is required to appear passive in professional relations with doctors, and act in a manner so as to make it seem that any recommendation made by the nurse is initiated, not by the nurse but by the doctor. Designed to support and protect a “... rigid organisational structure with the physician in clear authority”, the “game” inhibits open dialogue and may be seen as a transactional neurosis affecting both professions (Stein, 1978:117). Doctors declined the repeated requests by nurses that they write a DNAR order on the patient, and Gerri’s lack of control over the situation led her to feel anger and frustration.

Important to Gerri’s ethical reasoning was concern that nurses were supported in dealing with such an “awful” incident. The sister was supportive and tried to get doctors to write a DNAR order on the patient. Peer support was important. Gerri thought experiencing the incident with another nurse was helpful because it was good to be able to talk to someone else who had the same thoughts and feelings. Gerri was also concerned that the experience was traumatic for the student nurses present. She recognised they were shocked and confused, and supported them by answering questions, explaining and keeping them informed.

In conclusion, the use of narrative analysis is helpful in examining Gerri’s account of the incident. While many of the findings are similar to those from the coding analysis, the advantage of narrative analysis is that it gives a more complete view of the ethical incident and Gerri’s ethical reasoning. Unlike the coding analysis it respects the narrative quality of the text and allows insight into Gerri’s personal experience. As the narrative is considered in an uninterrupted and sequential way, it is possible to see how Gerri’s ethical reasoning developed, thus making it more complete and accessible. Poetic representation powerfully represents Gerri’s experience because, unlike prose, it closely resembles the way in which Gerri articulated her thoughts and experiences. In particular it makes clear Gerri’s emotional involvement and her

abhorrence at the possibility of being required to attempt to resuscitate the terminally ill and dying patient.

SALLY'S NARRATIVE – the unexpected death of a young patient

Hmm, I suppose at the time,
if you are in a difficult situation
you don't realise you are making
judgements
and ethical decisions.
Difficult situations,
there have been many.
The most difficult one
was a particular incident on night duty.
I was on with a sister,
a newly qualified 'D' grade
and a health care support worker.
Sister went off sick
about 3 o'clock in the morning.
I was left in charge.
The other two were doing the rounds
to check all the patients.
I was doing some admin work and
I did the final round
at about half past five in the morning
and found a [young] patient, dead.
He had been dead for over an hour,
at least, over an hour.
I tried to resuscitate him.
It was much too late obviously.
The people I was on with were extremely stressed.
I was stressed
but they were
extremely stressed
to the point where they couldn't function,
couldn't do what I told them to do
and felt afterwards
they hadn't performed properly
as I did myself.
Although thinking about it,
as I did for some months after,
I realised all the things I had done
I'd found personally had been right.
But I blame myself,
because I didn't know
he was dead
or had been ill.
They had a post-mortem

and found he had a massive tear in his aorta.
He had come in with an enlarged aorta,
they sent him for emergency surgery,
they didn't send any notes or X-rays.
So they couldn't do surgery
on the night he came in
and he died,
about eight hours later.
So,
but I felt it was my fault.
I felt that I should have been doing the checking,
I shouldn't have left it to them.
The qualified nurse was doing the check
every half-an-hour
and I thought, you should have known.
And I thought about it afterwards,
I thought you obviously didn't check properly.
But,
I'd a lot of problems.
I just couldn't get rid of the idea
it was my fault
and it was nothing to do with them.
Even though I thought
the registered nurse was accountable
and should have known.

I thought I should have known.
It's not particularly
reasonable or professional.
I thought there was a two-hour period
where I was doing other things
and I assumed that the patients
would have been checked properly.
I felt that I should have checked myself.

I felt I hadn't looked after
the patient properly and
hadn't given the proper care and
felt that I hadn't supported
the other people I was with
properly.
I hadn't taken into consideration
their age and very junior status.
I can't remember all the right
ethics terms.

I just felt
it's like
a dereliction of duty.
I thought I didn't fulfil my role,

I didn't support the people I was with
and it was my fault he died,
which took me a long time to come to terms with
and then I decided
no, it wasn't.
No,
but [now], when I'm on night duty,
I always do the checks myself.

Thirty patients
at the time.
Yea,
it had been a quiet night up until then.
The other thing was I didn't realise
how dire his diagnosis was
when he came in.
He had an enlarged aorta.
He should have been for emergency surgery but
I didn't really connect.
I thought his situation was so dire
he warranted emergency surgery on that day.
Why didn't they do it?
Maybe it's not that bad.
I didn't realise that the surgeon had just gone,
"O well I haven't got the notes,
I'm going home."

I thought,
why didn't they get them?
Why didn't they have them brought for them in a taxi
or why didn't they do something else?

He just had a deficit in blood pressure between both his arms,
which is a sign.
But apart from that he's up walking about saying,
"I feel like a fraud,
I'm quite well."

I'm sure it took me six months and more
before I could put it out of my head.
I was waking my boyfriend up
in the middle of the night.
He would say,
"What are you doing?"
"Nothing."
I told him in the end and he said,
"This is ridiculous."

What happened immediately afterwards,
mornings can be particularly busy

with pre-op patients
and we got on with it.
After the arrest
and we had moved his body
into the side-room,
we went on automatic pilot
and carried out our duties,
which seemed to surprise everybody else.
That worried me later on because I thought,
“How sharp was I really?”
Was I really thinking
while I was giving people pre-meds?
And getting them ready for theatre,
they had heard the alarm buzzer going off,
they were all very touched afterwards
because it obviously sounds like an emergency,
it’s so loud.
And I thought then as well,
“What sort of preparation was I giving these people,
what sort of signals
was I giving these people
who were just about to go to surgery?”
They were all terrified.
And what did I look like?
What sort of expression did I have?
Because I know I can look grim when I stressed.
And I thought,
“God.”
So the whole episode...

When the day staff came on
at half past seven
they looked very shocked as well
and were supportive.
They came to talk to us,
we were all in tears at this stage,
and they said,
“It’s not your fault,
da da da da.”
Which was a bit of a help at the time.
But I found later on when I was thinking
about the whole situation
I thought they were being really kind
and they were probably thinking,
“What were they doing all night,
they’ve been sitting on their backsides
by the desk,
and why didn’t they check the patients?”
But, the senior sister did come back later on
and told us about the results of the post-mortem

and said,
it was absolutely hopeless,
even if you had been there
when he had arrested
it wouldn't have made any difference.
But I still just kept saying,
"But I should have known,
I should have known."

[Those comments] did [help]
certainly, yea.
I knew that she knew
I was very stressed about it.
I didn't take time off work.
I came straight back in.

If it had been me
looking at it from the other side,
I would have thought,
"How could you not know?"
I knew as soon as I looked at him.
Other people must be thinking,
"They didn't bother to check the patients."
We all wrote statements
and said what had happened.
Yea they must think,
"They didn't bother to check..."
I know from the other people involved,
the 'D' grade,
she still mentions it
and talks about how terrible it was,
it's an abiding memory.

It makes it really important,
checking patients.
What most people seem to think
is to make sure
nobody is lying on the floor.
If they are not lying on the floor
they must be alright.
And I've explained to people
when they are going around
to check what exactly they are looking for.
I don't know whether they listened
or whether I listened
when other people told me,
or did anybody ever tell me?

Hmm,
I was trying to be

as normal as possible.
I don't know how normal I looked
or behaved.
But I tried
as I was explaining about pre-meds,
doing the pre-op checks
and chatting to patients,
but I can't remember what I said.
And because the arrest buzzer had gone off
and was going for a long time,
they all knew
something was going wrong.
There were screens across the corridor,
and moving beds about,
and there were three other men
in the bay with him as well,
who heard everything going on
with the team coming as well.

The other thing that happened,
which we all spoke to [the lead nurse] about
was the fact that when the team came
they decided after twenty minutes
there was no point
and they were going to stop,
and the anaesthetist started to show
the junior house-officer
how to do chest compressions.

I snapped really at that point
and I said,
"I thought
we'd finished,
what are you doing?"
And he said,
"This man has been dead for five hours,
core temperature is below 35,
what are you talking about?"

He seemed to think,
"Well ok,
maybe what I am doing is out of order."
Maybe he didn't think it was out of order.
I certainly did.

They didn't show respect for the person.
He was talking about pull "it".
He said, "Pull it over towards you."
And then walked over.
I just thought,

“God, that’s appalling.”
So we did bring that up
and we’d spoken to someone else
about that
and I said,
“You should definitely speak
to someone
and write it down
and see if they can discuss that with the team.”

Yea, [he did stop
once I raised the objection]
they just walked off.

I just remember in the middle,
the health care support worker,
I just asked her to go
and check the other patients
and explain to them.
Not to explain what was happening,
but just to check and reassure them,
make sure they were ok.
There were people
who were developing chest pain
when they got stressed
and so I thought,
“What’s happening with the rest of them?”
The three other men in the room
Could all get up and walk
and they all left the room
and went into the day room.

They did that of their own volition
So the health care support worker
went and spoke to them
and got them cups of tea.

One of the patients in that bay
was due to go for surgery that day.
He was an elderly man.
So he must have said,
“A young man,
younger than me
who had died.”
They obviously know very quickly
what’s happened.
I didn’t even see him afterwards
because I was days off after nights then.
And I didn’t even see him
after his surgery.

I can only guess how he felt.
The other two patients
just asked questions
about what had happened,
“Did he die?”
And I thought,
well yes it is important
to tell them the truth
and not to lie.
It was quite obvious
what had happened.
They wanted to know what had happened
and why,
which I couldn’t at that stage
really tell them anything about,
because I didn’t know.
I guessed,
but I wasn’t really sure.

My first thought was,
he may be dead,
but it’s still his business,
it’s confidentiality.
It’s his family’s business.
His family weren’t even there at the time.
But I thought I need to give
some information.
I wasn’t going to go back and say,
“O, the results of the post-mortem come through
and this is what happened to this man.”
But I did explain that
yea, he had died.

I thought that’s
about as much as I could tell them, really.
Especially
as his family hadn’t been there.
Some patients strike up a really close relationship
and do know quite a lot
about one another,
and their families
and their illnesses.
They didn’t know him particularly well.
I just thought,
“No it’s confidential
this information,
what’s happened and his condition.”
But I did need to tell them
he had died.
I think maybe because they need to trust

me
and if they knew
then they would know if I said,
“No, he’s very ill.” Or,
“I can’t tell you.”
They wouldn’t trust me.

From the start
he was away round the corner
away from the desk.
He should have been
monitored
and by the desk
because his condition was critical.
He should have had surgery that night.
The conditions
that you work in
are all very cramped
and if a patient becomes ill
there’s people two feet away
who can hear everything that’s going on.
For the relatives as well
we had to move someone
out of a side-ward
and move him in there
for his family,
his wife,
to see him afterwards.
The duty manager said,
“Well how are you going to do this?”
I think she wanted me to prevent
the rest of the ward knowing what had happened.
I just had to close the doors,
put a screen across
and wheel the bloke in.
There was nothing else I can do.
I didn’t get very much support
from the cardio-thoracic surgeon
on call.
He didn’t come for
twenty minutes after the arrest call
went out.
I assumed they were bleeped at the same time.
Someone in the team
bleeped the cardio-thoracic team
and they just came
and looked at him,
shrugged their shoulders
and walked off.
I felt they should have stayed

to speak to the relatives
who were racing on their way
to the hospital.
They actually knew he had died
before they got here.
The duty manager spoke to his wife
[on the phone].

She asked.
She suggested they come
to the hospital now
and she said,
“Has he died?”
So she said,
“I’m sorry, yes he has.”
And she said,
“Is this a joke?”
I wish it was.
Apparently, his body was on the ward
for quite a long time
and his family were here
for a long time
before any of the surgeons
came to speak to them.

The duty manager was quite supportive.
She stayed
for quite a while afterwards
and made phone-calls to the porter
and things like that.

To come to take this man away.
For some reason
he stayed up here for ages.
There was no one else here
who I could call upon really.
I thought afterwards
there should have been someone more senior than me
because I was a [junior nurse]
and hadn’t even got the Advanced Life Support.

I mean,
if he had been in a condition
where he could have been resuscitated
I would have been useless as well.
There should have been someone there.
It is still the case
that people are in charge on nights
and they are without
certain qualifications.

And when an arrest happens
it's usually chaotic
and panicky.
I did ask about that later on
and was told that I didn't really need it.

The Advanced Life Support,
or if I did want to do it
I could pay for it myself,
which was three hundred quid
and I thought,
"I can't really afford that."

The staff development sister
who was here at the time
came up that morning
and spoke to us afterwards
and said that if we wanted to come to speak to her later
she would be available to talk,
but we didn't.
We talked among ourselves
and Quincy,
I spoke to him when he came on because
he doesn't give you any nonsense.
And if he thought you were wrong
he would tell you, you were wrong
and he wouldn't try to flannel.
It was really among ourselves,
we talked it over
and over
and over
what had happened.

At the beginning
we were all blaming ourselves
and eventually
thought about various things
that had happened
and how we dealt with it.

We weren't offered any
formal counselling
or anything like that.
We could have sorted that out
if we wanted to.

When I think about it now
it disturbed me for about six months
and it was really too long
to be thinking about that.

And perhaps if I'd spoken to someone else
about it and got someone else's point of view
from outside the ward
it may have helped.

When I think about it,
my thoughts about
what had happened
were very selfish.
I kept thinking,
"Me, me, me,
what didn't I do
and how much of this is my fault?"
On that morning
how much time did I really take
and what sort of face did I present
to the other people
who were still there?

I mean,
your first thoughts,
what did I do?
What did I do wrong?
What should I have done?

Probably selfish
because I think,
"Now I feel so bad about this,
poor me."
It's not like,
"O poor you
because you're still here
and he isn't."
And his wife,
only married three months
and it's dreadful.
So,
yea I did seem to feel
quite sorry for myself.

Hmm,
I think it is probably natural.
Yea,
it's quite dramatic
and stressful
and yea.
(S36-407)

Commentary

The ethical incident

In her narrative, Sally describes how she had been left in charge of the ward while on night duty when the sister went off sick in the early hours of the morning. She had only a newly qualified staff nurse and a health care support worker for support. At one point Sally went to check the patients and found a young patient dead in his bed. He had been dead for some time. Resuscitation attempts were unsuccessful. In her narrative Sally explores the ethical nature of the incident and the ethical appropriateness of her actions.

Sally's ethical reasoning and decision-making

In her narrative Sally uses a combination of deontological and teleological thinking to guide her actions. Deontological thinking is represented by reference to her professional “duty”. In a number of respects she thought she failed in her obligations. She felt she was responsible for the patient’s death and had failed to support her colleagues properly. She refers to the sense of blame she felt as a consequence. Eventually she came to terms with the incident, considered that she had acted appropriately at the time and decided she was not to blame. Sally’s sense of professional duty motivated her to continue to care for patients despite the fact that she and her colleagues were greatly affected by the stress of the incident, to the extent that at the time they had difficulty in functioning. She explains how, she continued on “automatic pilot”, and was concerned at the level of her performance and the effect this may have had on patients. She describes her strategy as one of trying to be as normal as possible.

Much of Sally’s narrative includes teleological thinking in that it represents a consequentialist reflective process during which she considers the details of the incident in order to explain how it happened and could have been prevented, and to determine the ethical appropriateness of her actions. She thought there was little to suggest the seriousness of the patient’s condition. He had been admitted to the ward that evening as a referral from another hospital. He was a young man who was

walking about and had said to her, “I feel like a fraud, I’m quite well.” It was only later, after the event, that the seriousness of his condition became apparent. With hindsight one clinical sign, a difference in blood pressure in the patient’s arms, had suggested he might have had a serious condition. Sally thought the patient should have had surgery shortly after his admission. In fact, because the patient had been transferred without his hospital notes, doctors decided to attend to him the following morning. Sally questioned why they did not organise for his notes to be delivered by taxi that evening.

Features of Sally’s ethical reasoning, such as her concern for non-maleficence, her use of empathy, and her concern for professional relations with patients, are representative of the ethic of care approach. She was concerned about the possible harmful effects the incident had on other patients. During the resuscitation attempt she asked the health care support worker to check that other patients were all right, as she was aware that patients whose beds shared the bay where the incident took place had gone to sit in the day room. In particular she was concerned at the effect the incident had on patients who were to have surgery a few hours later. Sally empathetically attempted to appreciate what they were thinking. Sally’s concern for nurse-patient relations was demonstrated by her appreciation of the importance of honesty and trust. She thought patients understood the significance of such incidents, and felt it important to be honest in informing them of the patient’s death. At the same time, Sally felt it important to respect the confidentiality of the dead patient and his family. She recognised that patients sometimes develop close relationships amongst themselves and thought, without giving details, she needed to inform them that the young man had died. Sally thought it was wrong to evade the issue because patients needed to trust nurses and such trust was dependent on honesty.

Sally’s ethical reasoning was also influenced by the nature of the professional relationship between nurses and doctors. She was critical of the behaviour of doctors. She thought the cardio-thoracic surgeon on call failed to support her and was late arriving at the arrest scene. She was particularly critical of the actions of the anaesthetist who at the cessation of resuscitation efforts, started to use the patient’s body for the purpose of teaching chest compression to a junior doctor. Sally thought this was disrespectful and spoke up on behalf of the dead patient. In fact, Sally

described herself as having “flipped” at this point. The anaesthetist stopped when she challenged him. Sally was also concerned for the welfare of the patient’s relatives and again was critical of doctors. She thought they should have stayed on the ward to talk to the relatives after efforts at resuscitation had stopped. As a consequence, the family waited a long time before doctors came to speak to them.

In her narrative Sally reflects on the importance of professional support amongst nurses. She thought senior nurses were supportive. The senior sister and the duty manager helped by doing practical things such as making phone-calls. The staff development sister offered Sally the opportunity to talk about the incident if she wished. Sally also thought the day staff were supportive when they came on duty, but she could not help thinking that while they were making supportive comments they were thinking to themselves that she and the other nurses were negligent. Sally’s main support came from her peers with whom she repeatedly went over the incident. Also of help was an honest appraisal of her personal performance by a nurse who was known to be frank and “not to give any flannel.”

The personal distress this incident caused Sally is evident in her narrative. Its effects were long term and it took her six months to get the incident out of her head. It was, for Sally, a terrible incident and she describes it as an “abiding memory”. Sally was not offered formal counselling at the time of the incident which, she thought, might have helped. She was also disturbed by the fact that she felt her thoughts about the incident were selfish, but reasoned that selfish thoughts were probably natural given the traumatic and stressful nature of the incident.

In conclusion, the use of poetic representation to analyse Sally’s narrative powerfully portrays her experience. The horror of Sally’s experience, the long-term effect it had on her, and the way in which she ethically reasoned and made decisions in such difficult circumstances are all more apparent than in the coding analysis. By using poetic representation it is possible to portray the emphasis Sally gave to some of her words and comments. The reflective process of Sally’s self-questioning, her sense of self-blame, and her rationale for concluding in the end that she was not to blame and had acted in an ethical manner are all very apparent.

TINA'S NARRATIVE – a patient is misinformed regarding her diagnosis and prognosis

Another incident,
which was fairly recent actually.
It was
to do with
giving lung surgery patients
diagnosis and histology results.
It was in outpatients,
and a lady had come back
at her follow-up appointment
to be assessed following her operation
and also to have her histology results
given to her.
If I can remember
she had an
open pleural biopsy
as opposed to a full blown thoracotomy.
Also she came back at about two weeks
as opposed to four to six weeks
because she hadn't received her
histology results before she'd
gone home.
Her results showed she had mesothelioma.
Most studies show there is
100% mortality
within two years.
So, it's quite
a rampant malignancy to have.
When she came into clinic,
the registrar asked her to take her top clothes off
to have her wound examined.
I went in as a chaperone.
Everything was fine.
It had healed up perfectly well.
She said to me,
after the registrar had left that room,
"I feel so much better.
What I think it was,
was the fact that I had flu a few months before
and I never really shook that off."
Now, I was aware of the results,
at this stage
but knew the registrar
was going to inform her.
So, I said nothing.

The registrar
explained to her
that we had got the results.
He said she would recall
her referring chest physician had mentioned
it might have been a cancer.
She said, yes she was aware of that.
But her tone of voice implied
that was just brushed aside,
she hadn't given it any more thought.
The registrar said,
"And it does appear
that the results show
you have got a cancer."
She was quite shocked at this.
I felt she was
so shocked
the registrar tried
to give her comfort and support
but did not give her the full picture
because he was possibly afraid
of her crying,
maybe,
and breaking down in the consultation.
He went on to explain
it was a cancer
but she shouldn't be too alarmed
because if she was going to have
a cancer
that was the one to have.
He would refer her back
to the chest physician
at her local hospital
to receive treatment
appropriate for her malignancy.
She, I think was devastated
at these findings
and there was little else said
apart from "goodbye."
The woman got up
and walked out of the room.
I went with her
but didn't know what I could say,
in view of what the registrar had said.
I would have loved to have said,
"Lets just sit down
and try and get to grips with what he said",
but she was so shocked.
I think she just wanted
to get out of the hospital and go home.

I felt,
hmm, how did I feel?
I felt I wanted to say something
not only to the patient,
but to the doctor.
But I didn't quite know what to say.
He'd made the decision,
he'd told her what the results were
and who am I as a nurse to say,
"My understanding of malignant mesothelioma is
you die within two years of diagnosis?"
I can't say that in front of the patient
if he's said one thing.
That same afternoon
in the outpatients clinic
another gentleman came in.
He also had mesothelioma.
I didn't feel the message
was getting across
to these patients.
Surely there are plans
they will need to start making
for themselves and their families.
So, the next week
when the consultant
came back
I explained to him what I felt
had happened,
that I was concerned
about what was being said.
Not only that,
but many patients
were not receiving histology results
before leaving hospital.
I think sometimes,
because
doctors or surgeons
want to get rid of the patients
on a high note
rather than giving them the facts
that may bring them down
and leave the hospital
in a slightly
depressed or low fashion.
As it happened
when the consultant came back
he'd received a letter
from the referring physician.
The physician had said,
this particular women

was quite upset about the results
and the way they had been given.
So, it helped to emphasise
the point I was making.
I was pleased
I had spoken to the consultant,
who within an hour or so
had spoken to the registrar.
I don't know what was said
but he had raised the point
with the registrar
and it had been discussed.
I felt happier in myself,
selfishly maybe,
I had brought this to his attention
and he had dealt with it.
I'm not saying everything
is going to be fine now
but at least it makes me feel better.

We don't see patients after
so we had nothing more to do with her.
She would have had another appointment
with her chest physician at another hospital.
That was when it came to his attention
she wasn't happy
with the way
the results had been given to her.
I'm not quite clear what that meant
to be honest
because
I'm not sure if she still
to this day realises the significance of her diagnosis.

When I first started doing this job
I felt very uncomfortable
about talking to patients
who had been given the diagnosis of cancer.
I don't know
how
you go about learning
how to deal with patients like that.
I think it is something
that comes with experience.
You learn
from their experiences
and your own experiences
how to deal with those situations.
I know,
if there was an opportunity

to avoid speaking
to a patient
about a situation
or their cancer
I perhaps may have taken that option
initially.
But now I have learnt
that doesn't solve problems.
You will eventually get a phone call from that patient.
You need to speak
about that problem
or their diagnosis
in order to move on.
So you don't achieve anything really
by withholding information.
I'm not saying
that people are told lies
but they are not told all the truth,
I think to protect
the person who is giving the information.

Yes I know what you are saying.
Hmm, everyone is different.
Every situation is different
and so there is no right or wrong way
of dealing with any situation like this.
Because I've been doing this job
for four or five years
my ways have changed
I like to think it is for the better.
I think that
most of the time
nowadays
people want to know
their diagnosis
and are
eager to know their diagnosis.
I found
by withholding information
patients become suspicious
and become uneasy
with you.
They don't have as much confidence
in you
and they don't have as much respect.
And that goes right through
from the first time
I see them in the outpatients department before their operation
right through to
a year or more

down the track
or if they ring me up with a problem.
And if you are honest with the patient
and if you say
you don't know
or that you will get back to them
or whatever
they respect you for it.
They would rather know
that you don't know the answer
than you waffle
or you give them information
that is not necessary.
Because it is unsettling for them
and it is unsettling for their relatives
and friends.
In the long run nowadays,
patients do want to know,
they have a right to know,
they know they have a right to know.
And there are people
who will be so grateful
they have been told
so that they can make future plans.
Especially in this situation where
this lady will,
I would imagine,
be dead
within less than two years now.
And she will need to make plans
for the rest of her family
or help them make plans.
I don't think that's fair
to withhold information.
Maybe, like you suggested
to try and protect them,
maybe you are protecting them initially
but sooner or later
most of them will want to know
the full story,
the full picture.
Of course there will be people
who will not want to know
and even if you tell them
they will choose
not to receive that information.
But I think nowadays
people are
more aware of their rights
and know that

they need to know
and want to know
and will go out of their way
to find out more information now.

Yea, and who are we
to deny them the information?
With our specialist knowledge
we are the ones that
should be helping them
make decisions
and guide them
through the next couple of years.
As you say,
you are almost being
negligent
by not giving them
all the information
that we know.
(T280-423)

Commentary

The ethical incident

Tina's narrative concerns an incident where a doctor failed to fully inform a patient about her poor diagnosis and prognosis. Following explorative surgery a few weeks earlier, the patient had returned to the outpatients' clinic for a check-up and to be informed of her diagnosis and histology results. Tina knew the patient had a malignant mesothelioma and a maximum life expectancy of two years. Her professional role was that of chaperone to the patient while being seen by the doctor. Tina was sensitive to the fact that the patient did not suspect that she had a terminal disease. The patient had passed off her illness as having the "flu", which she never "shook off". Tina witnessed the doctor inform the patient she had cancer and noted that the patient was shocked. In an effort, Tina thought, to prevent the patient from crying and breaking down the doctor told her that "... if she was to have a cancer, this was the one to have." Tina faced a number of difficult ethical choices. Should she say something to the patient and if so what? Additionally, what action should she take regarding the doctor's failure to inform the patient?

Tina's ethical reasoning and decision-making

Tina's ethical reasoning and decision-making was influenced by her belief that the patient should be informed of her diagnosis and prognosis, and her concern to respect patient autonomy. Tina knew the patient's true diagnosis and its implications, but recognising the patient's devastation at being told by the doctor that she did "have a cancer", did not know what to say to her. She wanted to say something to both the patient and the doctor but at that stage her primary concern was to consider what the patient wanted, and she thought the patient simply wanted to go home. Tina did not meet the patient again and remained uncertain as to what information the patient received and whether she realised the significance of her diagnosis. She recognised that the issue of patients not being fully informed of their diagnosis and prognosis was a general problem and reasoned that they needed to know in order that they could make plans for themselves and their families.

Tina's perception of the professional relationship between nurses and doctors was influential. She portrays a hierarchical relationship where doctors were the main decision-makers, and clearly felt professional pressure to go along with the doctor's decision. Tina said the "doctor had made the decision" and felt she was not in a position "as a nurse" to contradict him, and fully inform the patient. Despite this, Tina's concern that patients were leaving hospital without being given their histology results motivated her to resist the professional pressure she felt, and to go above the doctor to inform the responsible consultant about her concerns that patients were not being fully informed.

Tina used elements from different theoretical frameworks in her ethical reasoning. She refers to her past professional experiences, and used teleological thinking to support her actions. In her career, Tina at first felt uncomfortable talking to cancer patients about their illness, but as she became more experienced realised that avoiding the issue did not solve problems. She thought, from a consequential viewpoint, it was best for patients to know their diagnosis and prognosis in order that they were able to address the situation they faced, and move on.

As already indicated, Tina's actions were motivated by her desire to respect patient autonomy. She reasoned that while some might choose not to know their diagnosis and prognosis, most patients wanted to know so they could plan their future. Additionally, Tina's ethical reasoning was also influenced by concern for the type of relationship nurses had with patients. She thought withholding information had a detrimental affect, as patients became suspicious and uneasy with nurses, and lost confidence and respect in them. Tina also thought patients respected nurses and were grateful when they were honest, whereas they and their relatives found it unsettling if nurses waffled or gave unnecessary information.

In her narrative Tina also refers to the concept of rights and the principle of justice. She thought patients had rights to information about their diagnosis and prognosis, and it was unfair to withhold such information. From a deontological perspective Tina considered nurses had a professional duty of care to inform patients and to use their knowledge to help and guide patients. She thought it was negligent of nurses not to give information to patients.

In conclusion, narrative analysis and the use of poetic representation is useful in presenting a more complete picture of Tina's ethical reasoning and decision-making than was possible using the coding method of analysis. The ethical incident and indeed the general issue of patients not being fully informed of their diagnosis and prognosis are clearly articulated. So too is the way in which Tina's ethical reasoning supported the decisions she made.

CHAPTER SUMMARY AND CONCLUSION

There are a number of similarities between the three examples of narrative. In each case, the ethical reasoning and decision-making of nurses was influenced by the context in which it took place. Professional relations with doctors were particularly influential. Nurses viewed this relationship as a hierarchical one where doctors were the main decision-makers. This caused nurses ethical difficulties. Gerri was faced with the possibility of having to attempt to resuscitate a terminally ill woman because doctors declined to document a DNAR order. Tina was faced with the situation where a doctor had misinformed a patient concerning her diagnosis and prognosis. Sally was

faced with a traumatic incident, which she thought might have been prevented if doctors had attended to the patient the evening he was admitted. Additionally, Sally's distress was increased as a result of the anaesthetist's decision to use the dead patient to teach chest compression to a junior doctor.

The use of power by doctors was a dominant feature of professional relations. Nurses faced hierarchical pressure to take actions they thought harmful to patients and contrary to their best interests, and which were therefore contrary to the nurses' personal and professional ethics. Gerri thought she might have to act in a way that would deny the patient a peaceful and dignified death, and Tina was involved in a situation that involved patients being denied their rights and possible benefits associated with knowing their diagnosis and prognosis. This dissonance between how nurses thought they ought to act and the actions expected of them, together with the fact that they had little or no say in decisions that gave rise to the ethical incidents or issues they faced, led to a sense of frustration.

However, in all three narratives, nurses were not powerless. They exercised power and were able to ethically reason in order to identify options, make decisions and take action. Gerri identified and discussed the options available to her over the resuscitation issue. Sally objected to the use of the patient's body as a teaching tool, and Tina contacted the consultant in order that patients be more fully informed about their diagnosis and prognosis.

Their narratives suggest that in their ethical reasoning and decision-making nurses used styles of thinking to be found in different theoretical frameworks. With the patient at the centre of their considerations their ethical reasoning is relationship-based and partialist in nature. This, together with other features such as emotional involvement, the use of empathy, and a concern for non-maleficence is characteristic of the ethic of care approach. Elements from other theoretical frameworks were also present. Teleological reasoning was represented by a concern that actions should be in the best interests of patients and cause them no harm. Deontological reasoning was represented by reference to a professional duty of care. In Sally's narrative she felt she failed in her professional duty and experienced a sense of blame as a consequence.

Within the context of the relationship-based nature of their thinking, nurses alluded to the importance of ethical principles. As well a concern for the principles of beneficence and non-maleficence, nurses were influenced by a desire to respect patient autonomy. Gerri was aware that the patient did not want to be transferred to another ward and tried to represent her wishes, and Tina contacted the consultant because she felt the patient should know her diagnosis and prognosis so she could make choices and “move on”.

In this study narrative analysis has served as a useful complementary method to the coding analysis. It has not only served to support findings resulting from coding, but has demonstrated its usefulness in its own right. Indeed it has certain advantages over the coding method of analysis. In comparison to the fragmenting process of coding, narrative analysis permits a more complete examination of the ethical reasoning and decision-making of individual nurses, allows insight into the personal nature of their ethical experiences, and illustrates the sequence and development of their ethical reasoning.

The use of poetic representation is helpful in bringing narratives to life. Compared with prose, it is a more accurate representation of the narrative of nurses, their ethical experiences, reasoning and decision-making. It serves as a powerful and effective method of representing the ethical experiences of nurses. It makes it possible for the reader to get a sense of some of the more intangible aspects of the experience of nurses, particularly their personal feelings and emotional responses. In the three examples analysed, it allows the reader to vividly ‘witness’ Gerri’s abhorrence at the idea of having to attempt to resuscitate a terminally ill patient, Sally’s distress at finding a young patient dead and the long-term personal effect it had on her, and finally, Tina’s concern that patients be fully informed about their diagnosis and prognosis so they can make meaningful choices.

Having outlined in this chapter the results of narrative analysis, and in the preceding chapters the results of the coding analysis, the purpose of the following chapter is to discuss the findings as a whole.

CHAPTER SEVEN

UNDERSTANDING THE ETHICAL EXPERIENCES, REASONING AND DECISION-MAKING OF NURSES

The aim of this chapter is to draw the analysis of this study to a conclusion and to explore how it has contributed to our understanding of the ethical experiences, reasoning and decision-making of nurses. The chapter consists of four parts. The first explores the relationship between environmental factors and the agency of nurses. The second part examines philosophical differences between nurses and doctors, as a means of understanding the philosophical basis for the ethical reasoning and decision-making of nurses. Part three consists of a final examination of the ethical reasoning and decision-making of nurses in order to explore its theoretical basis. The final part of the chapter discusses the conclusions and implications of the study, and includes a review of the aim, objectives and research question.

ENVIRONMENTAL FACTORS AND THE AGENCY OF NURSES

It has been emphasised in this study that the ethical reasoning and decision-making of the nurses must be understood within the context of the environmental factors in which it took place. The relationship between the two was complex and relates to the philosophical discussion of the relationship between free will and determinism. Though, as Thompson et al. (2000:284) point out, to talk of absolute freedom or absolute determinism might lead us into nonsense. Nevertheless, western tradition has since the period of the enlightenment emphasised the Kantian model of the autonomous individual empowered with the ability to reason, recognised as capable of moral choice, and whose thinking is impartial and detached. Kant's (1948:67) idea that morality be regulated by reference to natural law is characteristic of this acontextual approach. As a result, in recent times the contextual features of morality have been understated. Yet in this study, the ethical reasoning and decision-making of nurses was not detached or impartial, but attached and partial. Furthermore, it was

neither independent of, nor determined by, environmental factors. Rather, the relationship between the two may be seen as a form of mutual interdependence, where one influences the other and vice versa. To understand the ethical reasoning and decision-making of nurses it is necessary to consider both environmental factors and agency. Clearly, environmental factors were of ethical relevance, and it is these that I consider first.

Environmental factors

The environmental factors that influenced the ethical reasoning and decision-making of nurses were diverse in nature. They gave rise to a variety of ethical dilemmas and issues experienced by nurses, and influenced their ethical reasoning and response. Their mode of influence was often complex and unexpected. They included obvious factors of ethical relevance such as the nature of professional relations, and matters of organisation relating to surgical waiting lists, heavy workloads and staff shortages. They also included less obvious factors, such as the geographical layout of the ward, and the maintenance of stock levels in the ward storeroom. Results in this study suggest the need to consider the complexity and diversity of such influencing factors in order to inform our understanding of the ethical experiences, reasoning and decision-making of nurses.

One of the most important influencing factors, and one that has been referred to throughout the presentation of this study, was that of power relations. Nurses frequently referred to the hierarchical organisation of cardio-thoracic surgery and felt they faced ethical problems as a result of the decisions of others, and a decision-making process that excluded them. Nurses described what was on occasions an oppressive system. We have seen, for example, how a gendered organisation might have led to horizontal violence and the ill-treatment of new nurses. However, from a post-modernist perspective the power of organisations is exaggerated. From this perspective organisations are seen as mythologies constituted discursively to serve particular interests of power, and contested by other interests of power (Fox, 1993:48-9). Nevertheless, organisations, regardless of their mythic status, affect people by dictating practices designed to meet their needs and objectives (Fox, 1993:61).

The reality of organisational power needs to be recognised. On occasions nurses found it overpowering. Kerri, for example, did not resist hierarchical pressure and the professional power of surgeons and complied with their request not to inform patients or relatives of surgical mistakes made in theatre. Gerri and Lucy felt powerless when, despite voicing their objections, they had to transfer a dying patient to another ward. However, to view the system simply as overpowering and difficult to resist fails to explain the fact that nurses actually did resist. An analysis of power relations is useful in order to understand this resistance.

The complexity of power relations cannot be adequately explained by the concept of monolithic organisational power. To understand power relations it is useful to refer to observations made by Foucault (1980:198) who views power as "... more-or-less organised, hierarchical, co-ordinated cluster of relations", and postulates that power relations begin with relations between individuals. Foucault (1978:93) assumes that "power is everywhere" and is understood by focusing, not on organisations but, on the "micro relations" of power (Foucault, 1980:199). This conception of power relations helps explain the complexity of some of the interactions that took place. It allows examination of the intricacies of power interactions between people, the influence of, for example, personal character traits such as courage, experience, and communication skills, and the influence also of personal and professional histories and relations unique to individuals. To view power relations in this way helps explain why in hierarchical organisations the response of individuals to events differs. Thus we witness that in some circumstances nurses felt powerless and unable to resist organisational power, while in others they appear powerful and were able to resist.

Types of knowledge played an important role in power relations on the ward. Foucault emphasises the importance of knowledge in relations of power (Fox, 1993:62) and its use not only to understand the world, but also to influence the behaviour of others (Porter, 1998:213). This helps to explain some of the interactions that took place between nurses and doctors. Foucault (1977:27) argues that power relations are exercised through respective fields of knowledge. Hence certain interactions may be seen as a struggle for power expressed via different fields of professional knowledge. Nurses emphasised the differences between their professional knowledge and that of doctors. They emphasised psycho-social aspects

of health, whereas they viewed the knowledge of doctors as being concerned primarily with the physiological and clinical status of patients and their 'conditions'. Nurses were critical of doctors for failing to take a more holistic view of the health of patients and for subjecting patients to what Foucault (1973:119) calls the "clinical gaze", the process whereby doctors exercise power over patients by pathologising and objectifying them (Porter, 1998:220). Sally, for example, felt some doctors were unsympathetic to the discharge planning of nurses and took a mechanical perspective where they viewed patients like cars coming into a garage for repair (S433).

This conception of the relationship between knowledge and power offers an explanation as to why, for example, doctors were dismissive of nursing research with respect to wound care, and why they were reluctant to consult or refer patients to other specialists. It might also explain why doctors were not prepared to listen to Rebecca when she questioned on clinical grounds the appropriateness of removing the patient's chest drain. Such actions may be seen in the context of doctors attempting to maintain professional power and control by protecting their field of knowledge and declining to recognise that of others.

Of course, nurses also exercised power and in doing so were, according to their accounts, motivated by concern for the best interests of patients. In particular, they exercised power via their own 'field of knowledge'. Nurses used their knowledge of the psycho-social health of patients in order to ensure what they considered to be appropriate care, particularly with respect to discharge planning. However, the use of power in this way can also be criticised. The development of individualised care, the requirement to know about the 'whole' patient, and the use of psycho-social knowledge may be seen in Foucauldian terms as an example of "pastoral power" whereby professional power and surveillance over patients is expanded and increased (May, 1992). The gaze is no longer simply clinical, but includes the private subjective world of patients.

The exercise of power on the ward was not in itself a necessarily harmful ingredient in professional relations. Foucault suggests relations of power can be productive and should not be seen as simply repressive (Jones and Porter, 1994:96). For nurses, the ethical content of power relations revolved around motive and the purpose for which

power was exercised. We have seen in chapter two, how the conception of power as either authority or coercive depending on whether it is exercised legitimately or not (Wilkinson, 1999:7), is helpful. Nurses spoke critically of situations where they thought professional power was used contrary to the best interests of patients, and therefore coercively and unethically.

Nurses, then, used power and were not powerless or passive victims of the institutional and professional power that existed in the ward environment. Foucault (1978:95) points out that “Where there is power, there is resistance...”, and that resistance takes many forms such that there is not one but rather a “plurality of resistances”. We have seen in this study that nurses exercised resistance in a number of different ways. There is some discussion as to whether Foucauldian theory supports human agency. Freundlieb (1994:176-7) argues that because of his emphasis on discourse there is in Foucault an element of determinism. Nevertheless, Foucault (1997:300) contests that in relations of power individuals have freedom and employ certain strategies as a result of this freedom in their dealings with each other, a process he refers to as “governmentality”. According to Foucault (1980:201) power does not simply come from above, from institutions and organisations, but also comes from below. Indeed, organisational power, or “great strategies of power”, are dependent on the “micro-relations of power” (Foucault, 1980:199).

Despite the fact that there were occasions when nurses felt powerless and unable to resist professional and institutional power, from a Foucauldian perspective they had the capacity to be powerful such that environmental factors were not necessary constraints to their ethical reasoning and decision-making. Indeed, though in its pure form a state of liberty is associated with independence from controlling influences (Beauchamp and Childress, 2001:58), to the extent that their actions were not determined by environmental factors, nurses were at liberty to practice ethically. The question then arises as to what extent nurses in their ethical reasoning and decision-making took advantage of this liberty. This brings us to issue of agency.

Agency

We have seen how, despite the existence of restricting environmental factors, nurses made ethical decisions and acted as ethical agents. The term 'agency' is here used to signify the capacity for intentional action (Beauchamp and Childress, 1994:121), and the term 'ethical agency' to signify the capacity for intentional ethical action.

In order to demonstrate intentional action with respect to ethical situations, nurses had to first show the ability to identify such situations. We have seen that nurses in this study demonstrated a high degree of ethical sensitivity, as defined by Lützén et al. (1995), though it may have sometimes been diminished by environmental factors. Other studies report divergent findings regarding the ethical sensitivity of nurses. Oddi et al. (1995) reported that American nurses from a variety of clinical backgrounds had a low level of moral sensitivity. Whereas Smith (1996) found that American nurses from different practice areas identified ethical decision-making as a dynamic process they encountered routinely, but did not always recognise. In another American study Holly (1993) found that the willingness and motivation of nurses to engage in ethical decision-making faced environmental barriers such as lack of support or poorly defined mechanisms of support, time pressures, and hierarchic forces within the institution. Similarly, Holm (1997:102) identified a number of factors that might impede the identification of ethical problems by doctors and nurses, including work pressure.

While it has been recognised that environmental and institutional constraints may induce moral indifference amongst nurses (Johnstone, 1999:169), nurses in this study were not morally indifferent. Despite environmental constraints, they remained sensitive and motivated to practice in an ethical manner. Indeed, their ethical experience may be partly characterised as one of struggle against environmental constraints for ethical agency. Nurses frequently referred to the frustration they felt when environmental factors impeded their efforts to provide ethical care. As we have seen, nurses experienced moral distress and moral outrage (Wilkinson, 1987) when faced with situations where their ethical decision-making was limited by environmental constraints, or where they felt the decisions of others were unethical.

I have suggested that the frustration felt by nurses may be explained by reference to existential theory, particularly the notion of “bad faith” (Sartre, 1948). Existential theory and the notion of bad faith are useful in discussing ethical agency. Central to existentialism is the view that individuals are, within the context of their situation, ultimately free to make choices. However, existential freedom is associated with anguish and responsibility, and an act of bad faith occurs when there is an attempt to flee this anguish and responsibility of freedom. Nurses on the ward were, from an existentialist perspective, free to make ethical choices despite environmental constraints. They acted in bad faith when they failed to recognise this freedom or retreated from it, that is, failed to make ethical choices or succumbed to environmental pressures. Sartre (1948:52) is particularly critical of those who hide from this “total freedom” with “deterministic excuses”, and describes bad faith as a form of self-deception. Bad faith may be described as a deliberate refusal to recognise oneself as having both a past, a “facticity”, and a yet to be determined future, a “transcendence” (Sartre, 1958:49-70). It may be seen as an attempt to escape the anguish of personal freedom and the responsibility of one’s transcendence, and to view oneself as a thing, rather than as a self-determining individual.

Bad faith is a process of self-objectification, and in the language of Kant (1948:91) is to treat oneself simply as a means to an end, rather than as an end in oneself. There were a number of incidents that could be seen in this context. Kerry’s agreement, for example, to comply with the instructions of doctors not to inform patients or relatives of surgical mistakes in theatre, despite thinking they had a right to know, could be seen as an act of bad faith. Though Kerry reasoned that her compliance was motivated by her concern for good working relations in the interests of patients, she appears to have treated herself simply as a means to an end, the interests of doctors, or, as she claimed, patients.

There were many examples where nurses struggled against bad faith and the situational constraints that gave rise to it, and indeed struggled against the moral distress and outrage they experienced. The response of nurses varied. Holm (1997:188) uses the classifications of exit, voice, and loyalty (after Hirschman, 1970), and obstruction (after Lundquist, 1988) to describe the responses of Danish nurses and doctors to hierarchical decisions that conflicted with their ethical convictions. Similar

responses by nurses were noted in this study. Zoe, in the absence of a documented DNAR order, felt obliged to attempt to resuscitate the terminally ill and dying patient when he had a cardiac arrest. Such was her moral distress and outrage she decided to exit. She resigned her post and left nursing. Rebecca demonstrated voice, by raising again the discussion of whether the chest drain should be removed. Kelly demonstrated loyalty by doing nothing with regard to the decision of doctors not to inform patients or relatives of surgical mistakes. Nurses demonstrated obstruction when they delayed the discharge of patients they considered unprepared, or considered obstructive action, as when Gerri suggested that the nurse might “be slow” in reaction to a terminally ill and dying patient’s cardiac arrest where the patient did not have a DNAR order.

If, as this study suggests, nurses were ethical agents whose actions were not determined by environmental factors, we may ask then, to what degree were nurses responsible for the ethical nature of the ward environment in which they practised? Existential theory offers interesting observations on this question and suggests that nurses by their actions helped formulate, and were responsible for the ethical nature of the ward. From an existential perspective, individuals are self-determining to the extent that by their decisions in life they create themselves (Sartre, 1948:28). With this enormous freedom comes enormous responsibility, such that individuals are responsible in their actions not only to themselves, but also to all mankind. That is, via our actions we fashion ourselves and create an image of man as we would have him to be. Our actions are therefore morally significant and we need to consider what would happen if everyone acted as we did (Sartre, 1948:30). In fact, echoing Kant, Sartre (1948:32) comments, “So every man ought to say, ‘Am I really a man who has the right to act in such a manner that humanity regulates itself by what I do.’”

The notion of such absolute freedom has its problems. What guarantee is there, for example, that ultimately such freedom is not used to create an immoral self and society? What guarantee is there that nurses would not use such freedom to act inhumanely and create an uncaring ward environment? In existentialism there is an assumption that individuals, and in the context of this discussion nurses, will choose to act ethically. Existentialism therefore provides one of the most optimistic views of mankind ever advanced in Western philosophy because, despite situational

constraints, it assumes people will choose to be humane (Solomon, 1972:318). Certainly, in this study nurses were strongly motivated to act ethically, and thereby humanely.

In the discussion so far we have seen that nurses, from the perspectives of Foucauldian power relations and existential freedom, were neither powerless nor were their actions determined by situational constraints. Indeed, in their professional relations they exercised power and, within the confines of their situation, were at liberty to make choices. According to existential thinking nurses were free moral agents who by their actions helped formulate, and were responsible for, the moral image not only of themselves but of nurses as a whole. In addition, by their actions they contributed to and helped formulate the ethical nature of the environment in which they practised. This conception of the relationship between environmental factors and the agency of nurses is reminiscent of structuration theory (Giddens, 1984), which combines structure and agency. Giddens (1984:2) argues that “In and through their activities agents reproduce the conditions that make these activities possible.” According to this theory power is seen as the capacity to transform structures, and structures do not simply constrain human action, but to some extent enable it (Wilkinson, 1999:16).

This study emphasises the need to consider the complexity of environmental factors and their influence in order to understand the ethical experiences, reasoning and decision-making of nurses. It is to the ethical reasoning and decision-making of nurses that I now turn. In doing so, I wish first to consider findings I have mentioned but not yet fully discussed, which cast light on the philosophical underpinnings of the ethical reasoning and decision-making of nurses in this study.

PHILOSOPHICAL DIFFERENCES WITH DOCTORS

Nurses frequently spoke of differences they felt existed between them and doctors. An exploration of such perceived differences helps us understand the philosophy underpinning the ethical reasoning and decision-making of nurses. Certain differences appeared profound and were ethical, ontological and epistemological in nature.

Nurses thought doctors had a different perception of the best interests of patients, a different view of patients, and a different knowledge of patients.

Ethical differences

Throughout the presentation of this study's findings we have seen numerous occasions when nurses felt they had ethical differences with doctors. Such differences often arose over matters of professional practice, and over the perception of the best interests of patients regarding care and treatment. We have seen, for example, in chapter three how nurses struggled against hierarchical decision-making they thought contrary to the best interests of patients over matters relating to prescribing patient medications, wound care, and the reluctance of doctors to consult or refer patients to other specialists. In chapter four we noted nurses perceptions of ethical differences relating to the late cancellation of patient surgery, patient discharge and planning, and resuscitation.

While it is not necessary to revisit such examples, it is I think useful to refer to two further illustrative examples of ethical difficulties nurses felt existed between them and doctors. The first involved Quincy, who spoke of the way in which doctors sought patient consent for surgery. He thought doctors often talked people into having surgery they did not really want. In contrast, Quincy thought nurses would take time to discuss the situation with patients in order to consider important issues such as their quality of life, the advantages and disadvantages of surgery, and the possible risks involved. He explained:

... a lot of the time surgeons will do operations on people who don't really want it and they've been talked round into having it done, whereas nurses would sit there and speak to them about it... The nursing side will see that the patients are actually well and they have a good quality of life without having surgery and... they will be a high-risk patient. And the doctors will still talk them into it and actually take them for the surgery. And the majority of them do that... [Nurses consider the]... quality of the life they've got... because it's like they could live long enough with just medical therapy, whereas they're going to come for surgery and may well be dead within twenty-four hours. It's like, I would balance that up more, the nurses would balance that up more than the doctors do. (Q328)

The second example involved differences nurses thought existed between them and doctors over the treatment and care of terminally ill patients. Nurses felt it was in the best interests of such patients to be allowed a peaceful and dignified death, and believed that doctors were reluctant to allow terminally ill patients to die. As we have already seen in earlier chapters, Gerri and Lucy were faced, in the absence of a DNAR order, with the possibility of having to attempt to resuscitate a terminally ill patient with cancer. Both nurses thought this was not in the best interests of the patient and would have denied her a peaceful death. Instead of authorising a DNAR decision on the patient, doctors referred the patient to the oncologists. Both nurses thought doctors found it difficult to accept the inevitability of death in terminally ill patients. Lucy explained:

I don't know whether they just thought that because surgical doctors usually treat the patient... it's not like in a medical ward when you allow the patient to die if he needs to die. The surgical doctors really, they treat the patient and the patient goes home. And the fact that actually one of the patients weren't going to go home, whether that was hard for them to accept as well. And they just did not want to sort it out. They just would not believe that one of their patients was literally dying. That was really bad. (L211)

Gerri also thought doctors would not admit defeat and found it difficult to accept there were some patients they could not help. She commented, "... my own personal theory... they just won't admit to defeat... And they don't want to admit that they can't do anything..." (G104&233SN).

Though different, both examples illustrate that nurses identified fundamental ethical differences between themselves and doctors over matters relating to perceptions of the best interests of patients. Nurses viewed doctors as interventionist by nature, whose inclination is to use their medical-surgical orientation and knowledge to treat patients in order to cure and maintain life. Their knowledge and abilities in this respect are seen as powerful, and failure is difficult to accept. Nurses thought other considerations, which they considered important, such as quality of life, were less important to doctors. Doctors, on this account, appear to see patients as the objects of their endeavours whose role is to accept the treatment and cure offered. Clearly nurses have here identified both ontological and epistemological differences with doctors,

and in many respects such differences were the basis for the ethical differences nurses felt existed between themselves and doctors.

Ontological differences

The belief that doctors had a different ontological view of patients was at the heart of differences nurses felt existed between themselves and doctors. Nurses thought doctors regarded patients in a fundamentally different way and as a consequence had a different relationship with them. We have already seen that nurses enjoyed a close relationship with patients. They thought this was not necessarily the case with doctors. Winny, for example, commented, “I don’t know whether it is a good or a bad thing but patients tend to be more familiar with nursing staff than they do with medical staff” (W569). She continued by pointing out that patients tended to be on first name terms with nurses. Winny felt this was not the case with doctors because they did not know patients (W603).

Xaria also thought doctors perceived patients differently. She noted that in comparison with doctors, nurses would talk and listen to patients more and gather information in that way. Xaria’s personal approach was to apply the Golden Rule and felt that in doing so she treated the patient as a human being. She thought nurses were more involved and cared more. Xaria emphasised the importance of having psycho-social knowledge of patients in order to organise and advance their care. She explained:

... [doctors]... see patients in a different perspective... Let me give myself as an example. If I saw a new patient after surgery for the first time I’d think, “Right, what have I got to do for this patient, number one.” And then, assess him through the paper first, what I’d get from his notes and things and then go and talk to the patient first without the notes. Don’t sit there with paperwork or anything. Just go and have a general conversation with the patient and bring in, “How do you feel?” “How’s your appetite?” etc. Just talk and get a lot of information that way. I don’t think doctors do that enough... personally myself I see the patient as, right, if this was me, what would I want? Then I personally feel I treat them as a human in that sense. But in the back of my mind there is always, “He’s here because he has had surgery and there are these risks as well.” So I have to think like a professional as well. Yea, so whatever a patient is telling me I try to relate it at some point, “Is it

connected to why he has come in here?” Is it related to that? If it is not then it must be a personal problem... Nurses have much more time than doctors do. They don't just see them as numbers on a piece of paper that they have to get through by the end of the week, I don't think. They do care more because they are more involved with the family, with the patient themselves and they have to make referrals and things. So they have to know more about the patient in order to advance forward and help that patient. (X361&375)

Nurses felt that one of the major differences between them and doctors regarding the way they related to patients concerned the degree to which they became emotionally involved. Nurses spoke of how they became emotionally involved in their professional relations with patients but felt this was not the case with doctors. This was clearly illustrated by Gerri's comments in the chapter on narrative analysis. As we saw, Gerri thought the difference between nurses and doctors over emotional involvement was so profound that doctors were unable to appreciate the emotional involvement of nurses or how nurses felt when faced with difficult situations. With respect to the incident where, in the absence of a DNAR order, nurses were expected to attempt to resuscitate a terminally ill and dying patient, Gerri thought it pointless to inform doctors of nurses' feelings. She concluded:

So, I think you tend not to bother telling them, you know, “Will you put this women ‘not for resus’ because we are going to have to leap all over her and we know her and we feel sorry for her.” Because that will get you absolutely nowhere. (G197SN)

The perception by nurses that doctors had a different ontological view of patients appears to be supported by the findings of Holm (1997) in his study of the ethical reasoning of Danish nurses and doctors. Holm (1997:120) found an appreciable difference in the statements of nurses and doctors on the importance of maintaining relationships with patients, and suggests that this is a function of their working conditions, that is, it is easier and more necessary for nurses to establish relationships with patients.

Epistemological differences

Closely connected to ontological differences, nurses also thought there existed epistemological differences between themselves and doctors. Such differences were

characterised by the perception of nurses that they, unlike doctors, had a holistic perception of patients. Yvonne referred to this issue. She thought doctors were less emotionally involved in the care of patients and as a consequence differed from nurses epistemologically, as they had a different knowledge of patients. While she did not think her comments applied to all doctors, it appeared to her that doctors were tied to the “medical model” of care where they focused on physiological and clinical knowledge of the patient. They failed, Yvonne felt, to see the “whole patient” and as a consequence failed to appreciate that other things were important in the lives of patients. In contrast, Yvonne thought nurses appreciated the importance of the psycho-social world of patients, their existential world so to speak, and were therefore more aware of their needs in this respect. Yvonne gave a number of examples that illustrated her points. She also demonstrated how having different knowledge led nurses and doctors to different conclusions as to the best interests of patients. Yvonne explained:

I think for nurses it is very difficult because we're very much involved in the emotion of the patient as well as their physical well being. I think that sometimes the medical side are very distant from that. They just see their job, I'm sure they don't always, but sometimes it just appears that they are just plumbers who put the situation right. They don't see the whole patient and I think that that is quite difficult. I think sometimes they fail to recognise what else is going on with the patient's life. Sometimes we have thoracic patients who have lung surgery, have cancer, it just appears sometimes that their discharge is delayed and the doctors tend to hang on to them for various tests and investigations. And in actual fact these patients have terminal cancer, some of them, and don't want any further investigations and the decision-making is taken away from them. One of them on the ward at the moment has a wife who's stroked, who is in hospital and he wants to go home and look after her and he's got cancer himself. And he's still here because... the doctors it appears to me... won't let him go home. They can't recognise that the need for him to go home and nurse his wife is greater than the need to have a chest X-ray in two days time. Sometimes you think, “Will it change anything? Will it change your management?” He won't have further surgery. He refuses further surgery. He won't be involved in anything invasive apart from taking medication and then going home. So, why don't they send him home now and recognise that he's got other needs that are more important...? It's difficult to make them see that side of it... I think unfortunately... [doctors]... are still very wrapped up in the medical model of care. They are not all like it and I certainly wouldn't want to tar them all with the same brush. But their priorities are very different. I think as nurses we try to see what's important to the patient. You might have a little old lady who comes in for bypass grafts who's not worried

about the surgery in the slightest but she's worried about her budgies at home alone. You know, they won't see that her hurry for discharge is that or her cat or whatever. They'll just concentrate on her sternal wound or her donor legs or whatever. Their minds are quite different. They work very competitively and very much want to be seen having X number of patients... doing very well. Their priorities are just very different to ours and to the patients. Sometimes they don't see or want to see that there are other things happening. (Y206)

As nurses were more familiar with patients they had a greater knowledge of the psycho-social status of patients. To a great extent this point has been discussed previously, particularly with respect to patient discharge and planning. We have already seen how nurses felt that doctors' knowledge of patients concentrated almost exclusively on medical and physical health while nursing knowledge included the psycho-social health. As a result nurses and doctors made different and conflicting assessments of, for example, the readiness of patients for discharge home.

Winny also felt nurses and doctors had epistemological differences. She thought nurses were more aware of the "whole picture" and viewed patients in a holistic way. In contrast, doctors spent little time with patients and had a detached medical/surgical view of them to the extent that they tended to see and speak of patients in terms of their treatment or medical/surgical condition. Winny explained:

... the medical staff, they come on for the morning ward-round, again in the evening and maybe see the patient once or whatever during the day. So they haven't the same relationship I think with the patient as the nursing staff. They often talk about the patient as being a "cabbage" patient or the "valve" patient in bed number three... They are not with them every day as we are... I think nurses see them more holistically, the whole patient... They see the patient; they don't just see the operation... They have more dealings with the patient, more communication with the patient. They find out more. They've got the whole picture whereas sometimes the medical staff just see the operation... Often when we do ward-rounds, we discuss patients before we go round, they refer to them, "O yea, alright, was that the bypass, the double bypass, the triple bypass?" You know, and that's it in a nutshell for you. (W547&560)

Nurses referred to the holistic nature of nursing knowledge and made comparisons with the knowledge of doctors. Quincy, for example, compared the way in which nurses and doctors differed in their respective assessment of the readiness of patients for discharge home following surgery. He felt nurses had a holistic orientation where

they would take into account the physical, psychological and social status of patients, whereas doctors were concerned with the physical and clinical status of patients, and the requirement for beds. Quincy stressed the importance of ensuring patients were psychologically prepared, that it was safe to discharge them home, and the need to resist the pressure to discharge patients home early because of a shortage of beds. He explained:

I think nurses are more concerned with a person as an individual rather than their condition. And they are more concerned with the all round general wellbeing rather than just their surgery. You know, nurses... want to ensure that our patients are well before they actually go out, whereas doctors... seem to want to get them out as quickly as possible because they see the beds, they see their figures. Whereas nurses want to make sure that the patient is well enough to go home first... physically, psychologically and socially. You know, it's everything... nurses now put a lot more in-put into [discharge planning]... as soon as a patient comes in... we start planning their discharge... And, you know, psychological preparation for cardiac patients is probably more important than anything else. And... they will tell you themselves... they've got no confidence after they've had their surgery and that's what they are worried about, that they're not actually going to cope at home. So like the pre-planning part of it is so much more important that they're actually going to be ready for home within five or six days. And... we work with them towards that. It's like, it is safe for them to go home and they are not going to be sent home just because we need the beds. (Q278)

Yvonne thought doctors needed to practice in a more holistic way and that a more holistic training would help. However, she thought there were difficulties as many doctors were not trained in this country and therefore had a different “moral value base”, and cardio-thoracic surgery was a very competitive career that encouraged different priorities (Y319). Yvonne thought patient care would become more holistic if more case conferences involving doctors and nurses took place. Nurses had suggested this but for various reasons case conferences tended not to take place. Both nurses and doctors were very busy and had little time. Additionally, Yvonne felt doctors on the ward were not prepared to listen to nurses, and while they were skilful, their approach to care in the post-operative period was not holistic. She explained:

You're not listened to an awful lot sometimes. So it is very much a breed of doctors I think unfortunately that cardio-thoracics attract. And they are very good at what they do and I don't want to take away from them their

skill, experience or expertise, I just don't think that in the post-op period they're particularly holistic in their approach to patient care. (Y334)

To summarise this part of the chapter, the philosophical differences identified by nurses between themselves and doctors were ethical, ontological and epistemological in nature. Ethical differences existed over matters of professional practice, and a perception as to what constituted the best interests of patients in terms of care and treatment. Ontological and epistemological differences were to a large extent the basis for ethical differences between nurses and doctors. Nurses thought doctors had a different ontological view of patients in that they fundamentally regarded patients differently and developed a different type of relationship with them. Nurses felt that while they spent a great deal of time with patients, became emotionally involved and developed a close relationship, doctors spent little time with patients and remained emotionally detached. As a consequence of this there existed epistemological differences in the knowledge nurses and doctors had of patients. Nurses emphasised the importance of knowing the psycho-social status and adopted a holistic conception of patient health. In contrast, nurses viewed the knowledge of doctors as almost uniquely concerned with the physical and clinical health of patients.

Examination of the above differences nurses thought existed with doctors helps illustrate the broader philosophical underpinnings of their ethical reasoning and decision-making. Of particular note was the importance nurses attached to differences in the nature of respective professional relations with patients. The importance and nature of the relationship nurses had with patients influenced the relationship-based nature of their ethical reasoning and decision-making. Having examined aspects of its philosophical underpinnings, I now turn to a final examination of the ethical reasoning and decision-making of nurses.

ETHICAL REASONING AND DECISION-MAKING

It was found that the ethical reasoning and decision-making of nurses could not be understood by reference to any one particular moral theory. This is a finding consistent with post-modernist philosophy characterised by a sceptical mistrust of universal theories (Sim, 1998:3), and a tendency to question dominant and accepted

“metanarratives” (Lyotard, 1984). The ethical reasoning and decision-making of nurses was diverse and varied, and included features representative of both the dominant and alternative theoretical frameworks outlined in chapter one. Evidence of ideas from dominant theory such as teleology, deontology, rights theory, and the use of ethical principles including respect for autonomy, beneficence, non-maleficence and justice, could be identified. Similarly, ideas reflecting the use of alternative theory such as the ethic of care and virtue theory were also evident. Holm (1997:137) had similar findings in his study of Danish nurses and doctors who used elements from different moral theories, particularly consequentialism, deontological ethics, and virtue theory, in their ethical reasoning.

While there was evidence that nurses drew upon a number of different theoretical frameworks, one feature appeared common to the use of them all, that is, a focus on the patient and the nurse-patient relationship. Holm (1997:119) also identified the relationship nurses had with patients as important in their ethical reasoning and decision-making. The ethical reasoning and decision-making of nurses in this study constituted a form of relationship-based ethics. This focus influenced the way in which nurses applied elements of both traditional and alternative theory.

The two dominant theories of teleology and deontology were both represented in the ethical reasoning and decision-making of nurses. The application of teleological theory was represented by the desire of nurses to achieve consequences they considered “best” for the patient. This was illustrated by the constant requirement in their thinking to consider how to act so as to benefit, or prevent harm to, the patient. Hence the importance to nurses of the principles of beneficence and non-maleficence. Such an application of teleological theory differed from the way in which it is often presented in the literature where there is an emphasis on utilitarianism. While nurses might be sensitive to the utilitarian requirement of maximising happiness and minimising pain, their teleological thinking differed from utilitarianism in that their concern was generally with individual best interests rather than aggregate welfare. Holm (1997:118) similarly found that Danish nurses demonstrated in their ethical thinking a concern for consequences, particularly with respect to the wish to seek outcomes that were considered best for the patient.

The application of deontological theory was best illustrated by reference to what nurses considered to be a duty of care. The duty of care was directed to the patient and was symbolic of the patient-centred character of their reasoning. The notion of respect was clearly a fundamental aspect of the nurse-patient relationship and an essential component of their ethical reasoning. Furthermore, their respect appeared to be more than the response to a professional requirement, but something nurses valued in itself. The respect nurses showed patients could in some ways be explained by reference to Kantian (1948:91) deontology and the requirement of the “categorical imperative”, in particular with regard to the need to respect individuals as “ends”. There were examples where nurses objected to patients being used, in Kant’s (1948:91) terms, “simply as a means” to an end. Sally, for example, objected when the anaesthetist began to use the body of a young patient immediately after a failed resuscitation attempt to teach chest compression to a junior house-officer, and observed, they “... didn’t show respect for the person” (S220).

Kantian respect seems to accept the possibility that people may use each other as a means to certain ends, but holds that they should never treat others “simply” as a means to an end. It could be argued that nurses in this study used patients as a means of making a living. Similarly, we saw how nurses got satisfaction and emotional reward through caring for patients. However, it would be wrong to accuse nurses of treating patients “simply as a means” to an end, as nurses based their relationship with patients on respecting them, in Kant’s (1948:122) terms as “ends in themselves”. On the basis of such respect the actions of nurses were governed by a concern for the best interests of patients. In discussing respect as a moral concern Gibbard (1990:269) suggests that it is a crucial moral sentiment, but is a poor guide to moral action as it is not associated with clear standards. Its biological function is, according to Gibbard, related to reciprocity, as it motivates one to have protective concerns towards others.

Associated with the notion of respect was the importance nurses attached to respecting both the autonomy and rights of patients. Respect for patient autonomy was the basis for many of the nurses’ patient-centred concerns, such as patient choice and agreement, just treatment and rights, and confidentiality. It may be explained in terms of Kant’s (1948:107-8) emphasis on the importance of reason and “free will”. That is, individuals are deserving of respect because of their capacity to reason, make moral

choices, and their freedom to do so. Though their freedom is governed, according to the “formula of autonomy”, by reference to natural law (Kant, 1948:93). It is Kant’s emphasis on natural law that makes his philosophy amenable to the concept of human rights, as human rights have their origin in natural law theory (Buckle, 1993:166). There is a Kantian flavour to some of the comments made by nurses concerning the need, for example, to respect the rights of patients to information about their diagnosis and prognosis, in order that they were able to make autonomous choices.

Despite similarities to Kantian theory, the ethical reasoning and decision-making of nurses differed in significant ways. It was not purely duty-based, but also guided by a teleological concern for consequences. There was little evidence also that nurses referred to Kantian natural law and the concept of universal morality in their ethical reasoning and decision-making. Quite the contrary, decisions appeared to be made on an individual casuist basis with the emphasis on the particular needs of individual patients. Though there were similarities, nurses did not see respect for autonomy in unconditional Kantian terms, but in terms that were conditioned by the necessity of acting out of certain interests, principally the best interests of patients. Furthermore, nurses became emotionally involved in their ethical reasoning and decision-making, whereas Kant (1948:76-7) emphasises the importance of practical reason, uninfluenced by desires or passions and “independent of inclination”.

The application by nurses of the Golden Rule and the Golden Rule by Proxy might appear to have similarities with Kant’s notion of natural law, but was in fact quite different. Rather, it is a mechanism used by nurses to seek empathetic insight into the experience of a patient and to determine a course of action by imagining themselves or a loved one to be in the position of a patient. By doing so, nurses did not determine their actions on the basis of the Kantian question, could the action become a universal law? Instead they determined their actions by applying personal values in a particular situation. In this respect the application of the Golden Rule appeared linked to virtue theory with its emphasis on character and virtues. Essentially, while nurses did apply deontological reasoning, they did so not in the detached, impartial and acontextual way associated with Kantian theory. Indeed the ethical reasoning of nurses was often quite the reverse. With the patient and the nurse-patient relationship central, it was attached, emotional and contextual.

In a number of respects the ethical reasoning and decision-making of nurses resembled the application of the ethic of care approach. The importance nurses attached to their relationship with patients, their concern for beneficence and non-maleficence, their emotional involvement, and their use of empathy as a means of seeking insight into the experiences of patients, is characteristic of this theoretical framework. As most of the nurses in this study were female, this also reflects the view that this framework for moral reasoning is primarily representative of women (Gilligan, 1982). There were both advantages and disadvantages apparent in the use of the ethic of care approach. On the one hand it usefully emphasises that relations are an important part of our moral existence and influence our ethical reasoning, it highlights those features that have been ignored in traditional moral philosophy, and may thereby make our understanding of ethical reasoning less one-sided and more complete. On the other hand, its emphasis on partial thinking may be problematic in situations where impartial reasoning may be more appropriate, and the ethic of care approach tends to describe a moral response and does not necessarily provide clear guidelines for ethical decision-making.

Closely linked with the ethic of care approach was the importance nurses attached to virtues. The importance nurses attached to certain virtues and their identification of desirable character traits was suggestive of Aristotelian virtue theory. Virtue theory is significantly different from much of the ethical theory discussed so far because it is essentially concerned not with the nature of ethical action but with the nature of ethical being. Virtues relating to the capacity to work well within the nursing team such as approachability and supportiveness, cognitive and practical virtues such as wisdom and clinical skill resulting from experience, and personal virtues such as courage and confidence were amongst the many virtues identified.

The importance of virtues amongst nurses in this study is supported by findings from other studies. Holm (1997:152) found that the ethical reasoning of Danish doctors and nurses contained elements from consequentialism and deontology, but was most closely related to virtue theory. Lützén et al. (1995) also noted the importance of the virtue of wisdom for Swedish nurses practising in psychiatric and general medical-surgical settings. This was likened to Aristotelian *phronesis* or practical wisdom,

which is characterised by a capacity for moral insight and the ability to discern what choice or course of action is morally good. Lützén et al. (1995) noted that the virtue of wisdom was often associated with maturity and may be a necessary component of moral sensitivity in nursing practice.

Nurses also employed ethical principles in their ethical reasoning and decision-making. Their use appeared both helpful and important. However, their use did not seem to fit the model associated with the principlism of Beauchamp and Childress (2001), as they were employed within the broader context of ideas reflecting various philosophical theories. In the case of beneficence and non-maleficence within the context of teleology and the ethic of care, and in the case of respect for autonomy and justice within the context of deontology, all under the umbrella of a concern for the patient and the nurse-patient relationship.

Indeed, it might be more appropriate to view the use of principles, not so much as abstract principles, but as virtues within the context of virtue theory. Hence, respect for autonomy, non-maleficence, beneficence, and justice may be seen in terms of their corresponding virtues of respectfulness, non-malevolence, benevolence, and justice or fairness (Beauchamp and Childress, 2001:39). The principle of beneficence serves as an illustrative example. Seeking what was best for patients was central to the ethical reasoning and decision-making of nurses, and may be seen as an expression of the principle of beneficence. However, as beneficence tends to refer to beneficial actions (Beauchamp and Childress, 2001:165), it is more accurate, with respect to the ethical reasoning and decision-making of nurses, to refer to the motive to do good to others, that is benevolence. When viewed in this way, the concern of nurses for what they considered best for patients may be seen as a virtue. Similarly, Lützén and Nordin (1993) reported that benevolence, along with other virtues including charity, compassion and empathy, was important in the moral decision-making of Swedish psychiatric nurses. In this study ethical principles were not employed in a disparate way, but within a framework of thinking that had at its heart the relationship nurses had with patients.

To summarise the ethical reasoning and decision-making of nurses in this study: a picture emerges of ideas from different moral theories being used in a complementary

and supportive way, such that the deficiency of one theory is compensated by the advantages of another. This is different from the theoretical literature where moral theories are often presented in ways that appear antagonistic to one another. In this study, the harshness of teleology, for example, which judges moral actions solely by consequences, is compensated by the use of virtue theory with its interest in motive. The impartial and acontextual nature of Kantian deontology and ethical principles are compensated by the partial and contextual application of an ethic of care approach, and a concern for character and virtues. Conversely, the lack of guidance as to what constitutes moral action in the ethic of care approach and virtue theory is adjusted by reference to teleology, deontology and ethical principles. In fact, with respect to virtues, Kant (1948:59) recognises the importance of “talents of the mind” or “qualities of the temperament” and describes certain virtues as good and desirable in many respects. His argument is simply that their goodness is dependent on the will that employs them.

For a diagrammatic summary of the patient-centred and environmentally contextual ethical reasoning and decision-making of nurses in this study, together with some of the ethical issues they experienced, see **appendix 12**.

CONCLUSIONS AND IMPLICATIONS

In discussing the conclusions and implications of this study I have considered four areas, namely, knowledge, education, professional practice, and future research.

Knowledge

Regarding the contribution of this study to our knowledge, several conclusions can be drawn. It has been said that contemporary nursing is dogged by a negative expectation that nurses should not think (Dartington, 1994). This study informs us that nurses were sensitive of, and thought extensively about the ethical situations that surrounded them. Their ethical reasoning was both rich and diverse in nature. It did not represent any one theory of ethical reasoning, but consisted of elements from both dominant and alternative theoretical frameworks, used in a mutually complementary and supportive way.

With concern for the patient and the nurse-patient relationship at its centre, nurses employed what may be described as a relationship-based ethical framework that included elements from moral theory such as teleology, deontology, ethic of care, and virtue theory, as well as the use of ethical principles. From this it follows that, while the difficulty of devising a moral theory that is seen as universally compelling is recognised (Holm, 1994), nurses did in fact use a theoretically rich moral framework. It simply did not fit the mould of moral theory as traditionally presented.

This study also informs us of the sheer complexity and diversity of the ethical experiences of nurses. I have employed ethnographic methods in order to investigate the ethical world of nurses, and used research techniques such as narrative analysis, poetic representation, and verisimilitude to present the data as much as possible in the voice of the nurses who took part. To make it real, so to speak. This is significant, as there exists concern that nursing testimony and knowledge is invisible and silenced (Liaschenko, 1998:11).

This study also informs us of the importance of understanding how the ethical reasoning and decision-making of nurses is influenced by environmental factors. Such factors gave rise to the ethical difficulties faced by nurses and influenced their responses. Difficult environmental factors such as negative professional power relations with doctors and amongst themselves, being short-staffed, and having heavy workloads, not only exposed nurses to a variety of ethical difficulties on a daily basis, but also constrained and impeded their response. Such a situation gave rise to frustration and feelings of moral distress and outrage.

However, we are also informed that the responses of nurses were not determined by such environmental constraints, simply influenced by them. It is important to acknowledge that nurses were empowered, particularly with respect to their field of professional knowledge. In essence, nurses practised as ethical agents and were at liberty to make ethical choices. While some nurses found constraining environmental factors hard to resist, others employed various forms of resistance. As such, nurses contributed to and were in part responsible for the ethical nature of environmental

factors. The ethical climate, so to speak, of the ward was to some degree shaped by the response of nurses to it.

Education

Regarding the implications of this study for education, there are several conclusions. The fact that nurses faced difficult ethical challenges on a daily basis emphasises the requirement and importance of ethics education at undergraduate and post-graduate levels. It also emphasises the need for inter-professional ethics education in order to facilitate mutual understanding between members of different professions.

Findings in this study have implications relating to the way in which ethical theory is taught. The teaching of ethical theory needs to be more informed by empirical research and therefore more relevant, and representative of how nurses ethically reason in practice. There is a need to emphasise ethical accountability and agency and to address the ethical frustration, and moral distress and outrage that nurses experience. Furthermore, the diversity of ethical reasoning demonstrated by nurses suggests education needs to include an examination of traditional and alternative philosophical theory. In this respect it is necessary to take a pluralistic approach. Indeed, the need for spiritual and ethical pluralism in professional nursing practice within a pluralist society has been emphasised (Cusveller, 1998).

The scope of the content of ethics education needs to be widened such that it encompasses the complexity and diversity of the ethical experience of nurses. In particular ethics education needs to address environmental matters in order that their influence is understood. Subjects not usually associated with the teaching of ethics, such as the structure of organisations and their management, and power relations need to be addressed in order that nurses appreciate their ethical significance and are more equipped to deal with them. Addressing such environmental factors will help to enhance the ethical sensitivity of nurses. There have, in fact, been calls for a more context sensitive approach for nursing ethics (Lützén, 1997). Additionally, Seedhouse (2000:178) refers to the “ethics myth” in nursing whereby there is a belief in an emphasis on applying ethical principles and Codes to daily ethical, often dramatic, events without the need to explore and address the wider social world. Hence there is

a concentration on action-based theory and a reluctance to confront broader ethical questions relating to social factors and the nature of being.

The importance of virtue theory in this study is particularly significant with respect to education. It suggests that the response of nurses to ethical situations is ultimately a matter of character. Hence education should include concern for the refinement of character and motive. This implies that educational curricula should embrace a wide range of aims and topics such as personal and professional values clarification, developing ethical sensitivity, developing self-empowerment, communication skills, management of conflict, and perfecting desirable virtues, to name just a few. The importance of habitation and role modelling also needs to be stressed. Holm (1997:138) also noted in his study of the ethical reasoning of Danish doctors and nurses that ethical standards might be seen as a stable personality trait.

Professional practice

There are several implications for professional practice as a result of this study. In many respects the findings of this study are optimistic. Nurses are seen as ethically motivated, empowered and at liberty to make ethical choices. It is to be hoped that such a positive picture of the capacity for ethical agency is encouragement for nurses when considering and making ethical decisions in professional practice.

Findings in this study suggest that in order to develop professional practice nurses need to address environmental factors that cause ethical difficulties, dull sensitivity, and impede ethical reasoning and decision-making. It is important that nurses appreciate their role and responsibility with respect to the ethical nature of the practice environment, particularly with regard to matters of organisational structure and professional power relations. Nurses need to recognise their capacity to change structures, and greater involvement in organisational and managerial decisions is a necessity in order to create a more ethically sensitive ward environment for nurses.

The importance of virtue theory in this study may have a number of implications for professional practice. According to Cash (1998) virtue theory may be important in defining and sustaining the very practices and traditions of nursing. Hence, the virtues

of a good nurse are defined within a tradition. Findings in this study indicate this is a dynamic process as nurses engage in an existential struggle against bad faith and for recognition of their 'transcendence'. Clearly, old virtues of unquestioning obedience and subservience appear out of place in the present day. Nurses need to consciously participate in the continued evolution of what is considered to be ethical nursing practice.

In professional practice it is important that nurses take account of many of the virtues identified as ethically significant. The importance of virtues associated with teamwork and peer support has particular relevance to professional practice. Their use in assisting nurses to address ethical situations, and cope with the stress of doing so, must be recognised and reflected in nursing practice. Also noted was the importance of a supportive style of nurse management, and of authoritative figures that act as positive role models. Such role models need to demonstrate qualities such as being approachable, supportive and encouraging to others in order to assist nurses in their ethical reasoning and decision-making.

Research

This study also has implications for ethics research. The first concerns methodology. While I found the traditional coding method of qualitative analysis useful, it also has limitations. The use of poetic representation as a supplementary method of analysis I found liberating. It offers a fresh approach and allows meaningful insights into interview texts. This suggests the use of alternative methods of analysis offer rich opportunities.

Secondly, ethics research might be usefully expanded to investigate environmental issues such as the nature of organisations and power relations and their effects on the ethics of practice.

Thirdly, in this study I have focused attention on the ethical reasoning and decision-making of nurses practising in cardio-thoracic care. I was recently asked when presenting a seminar on the findings of this research, "What of the ethical reasoning and decision-making of nurses in areas other than cardio-thoracic care?" My honest

answer to this question is, “I don’t know”. However, while it was not an expectation of this study that the findings should be representative of other clinical areas, I strongly suspect that in many ways they are relevant. It is clear that more empirical research is needed to investigate the ethical experiences of nurses and their corresponding ethical reasoning and decision-making in different practice areas.

Review of the aim, objectives and research question

While it is for the reader to decide the success or otherwise of this study, I submit that it has successfully addressed its aim, objectives, and research question as identified in chapter one. The aim “... to explore the ethical reasoning and decision-making of nurses in professional practice”, and the research question “... how do nurses ethically reason and make decisions in professional practice?” have been addressed. The primary objectives have also been achieved. The presence or absence of a theoretical framework, or theoretical frameworks, that might represent the ethical reasoning and decision-making of nurses, and the degree to which types of ethical reasoning found in traditional and alternative moral philosophies are applied in the ethical reasoning and decision-making of nurses have been investigated. So too have the ethical experiences of nurses and the environmental and situational factors that might influence their ethical reasoning and decision-making. The remaining objective, to make recommendations based on the findings relating to the teaching of health care ethics to student and post-graduate nurses, and the provision of an environment sympathetic to the ethical reasoning and decision-making of nurses, has also been addressed.

Finally, my hope is that this study has helped to inform us of the ethical experiences of nurses and their ethical reasoning and decision-making, and that it will contribute to ensuring ethical nursing and thereby better patient care.

REFERENCES

- | | | |
|---|------|--|
| Adler, Patricia. A.
Adler, Peter. | 1994 | Observational Techniques. In: Denzin, Norman. K. and Lincoln, Yvonna. S. (Eds.) Handbook of Qualitative Research . Sage Publications, Thousand Oaks. |
| Aristotle. | 1953 | The Ethics of Aristotle – Nicomachean Ethics . Translated by J. A. K. Thomson. Penguin Books, Harmondsworth. |
| Åström, G.
Jansson, L.
Norburg, A.
Hallberg, I. R. | 1993 | Experienced nurses' narratives of their being in ethically difficult care situations. Cancer Nursing . 16 (3) pp. 179-187. |
| Åström, G.
Furåker, C.
Norberg, A. | 1995 | Nurses' skills in managing ethically difficult care situations: interpretation of nurses' narratives. Journal of Advanced Nursing . 21, pp. 1073-1080. |
| Atkinson, Paul. | 1990 | The Ethnographic Imagination: Textual constructions of reality . Routledge, London |
| Atkinson, Paul.
Hammersley, Martyn. | 1994 | Ethnography and Participant Observation. In: Denzin, Norman. K. and Lincoln, Yvonna. S. (Eds.) Handbook of Qualitative Research . Sage Publications, Thousand Oaks. |
| Ayer, A. J. | 1990 | Happiness as Satisfaction of Desires. In: Glover, Jonathan. (Ed.) Utilitarianism and Its Critics . Macmillan Publishing Company, New York. |
| Baier, Annette. C. | 1995 | Moral Prejudices: Essays on Ethics . Harvard University Press, Cambridge, Massachusetts. |
| Baier, Annette. C. | 1999 | The Need for More than Justice. In: Olen, Jeffrey. and Barry, Vincent. Applying Ethics: A Text with Readings . Wadsworth Publishing Company, Belmont, CA. |
| Beauchamp, Tom. L.
Childress, James. F. | 1994 | Principles of Biomedical Ethics . 4 th ed. Oxford University Press, New York. |
| Beauchamp, Tom. L.
Childress, James. F. | 2001 | Principles of Biomedical Ethics . 5 th ed. Oxford University Press, Oxford. |

- | | | |
|---------------------------------------|------|---|
| Beauchamp, Tom. L.
Walters, LeRoy. | 1999 | Contemporary Issues in Bioethics. 5 th ed. Wadsworth Publishing Company, Belmont, California. |
| Bentham, Jeremy. | 1990 | On the Principle of Utility. In: Glover, Jonathan (Ed.) Utilitarianism and Its Critics. Macmillan Publishing Company, New York. |
| BMA. | 2001 | Decisions Relating to Cardio-pulmonary Resuscitation – A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. BMA, London. |
| Brabeck, Mary. | 1983 | Moral Judgement: Theory and Research on Differences between Males and Females. Developmental Review. 3, pp. 274-91. |
| Brady, Ivan. | 2000 | Anthropological Poetics. In: Denzin, Norman. K. and Lincoln, Yvonna. S. (Eds.) Handbook of Qualitative Research. 2 nd ed. Sage Publications, Thousand Oaks, California. |
| Buckle, Stephen. | 1993 | Natural law. In: Singer, Peter. (Ed.) A Companion to Ethics. Blackwell, Oxford. |
| Burgess, Robert. G. | 1982 | Field Research: a Sourcebook and Field Manual. Routledge, London. |
| Burns, Nancy.
Grove, Susan. K. | 1995 | Understanding Nursing Research. W. B. Saunders Company, Philadelphia. |
| Callender, John. S. | 1998 | Ethics and aims in psychotherapy: a contribution from Kant. Journal of Medical Ethics. 24, pp. 274-278. |
| Calley, Peter. | 1990 | Moral learning in nursing education: a discussion of the usefulness of cognitive- developmental and social learning theories. Journal of Advanced Nursing. 15, pp. 324-328. |
| Cash, Keith. | 1998 | Traditions and practice – nursing theory and political philosophy. In: Edwards, Steven. D. (Ed.) Philosophical Issues in Nursing. Macmillan, Houndmills. |
| Chaplin, Clifford. | 1993 | An Exploratory Study into the Ethical Decision Making of Student Nurses. Unpublished MSc dissertation. |

- Childress, James. F. 1997 **Practical Reasoning in Bioethics**. Indiana University Press, Bloomington and Indianapolis.
- Clegg, Stewart. R. 1989 **Frameworks of Power**. Sage Publications, London.
- Clouser, K. D. 1990 A Critique of Principlism. **The Journal of Medicine and Philosophy**. 15, pp. 219-236.
- Gert, B.
- Coffey, Amanda. 1996 **Making Sense of Qualitative Data**. Sage Publications. Newbury Park.
- Atkinson, Paul.
- Cooper, Mary. 1991 Principle-orientated ethics and the ethic of care: A creative tension. **Advances in Nursing Science**. 14 (2) pp. 22-31.
- Carolyn.
- Corley, Mary. C. 1994 Prevalence of Principled Thinking by Critical Care Nurses. **Dimensions of Critical Care Nursing**. 13 (2) pp. 96-103.
- Selig, Patricia.
- Crisham, Patricia. 1981 Measuring Moral Judgement in Nursing Dilemmas. **Nursing Research**. 30 (2) pp. 104-110.
- Cusveller, Bart. 1998 Cut from the right wood: spiritual and ethical pluralism in professional nursing practice. **Journal of Advanced Nursing**. 28 (2) pp. 266-273.
- Dartington, Anna. 1994 Where angels fear to tread – Idealism, despondency and inhibition of thought in hospital nursing. In: Obholzer, Anton and Roberts, Vega. Zagier. (Eds.) **The Unconscious at Work – Individual and organizational stress in the human services**. Routledge, London.
- Davies, Celia. 1992 Gender, history and management style in nursing: towards a theoretical synthesis. In: Savage, Mike. and Witz, Anne. (Eds.) **Gender and Bureaucracy**. Blackwell Publishers, Oxford.
- Davies, Celia. 1995 **Gender and the Professional Predicament in Nursing**. Open University Press. Buckingham.
- Denzin, Norman. K. 1989 **The Research Act**. 3rd ed. Prentice Hall, Englewood Cliffs.
- Department of Health. 1992 **The Patient's Charter: A Summary**. HMSO, London.
- Dey, Ian. 1993 **Qualitative Data Analysis – A User-Friendly Guide for Social Scientists**. Routledge, London.

- Dierckx de Casterlé, B.
Roelens, Agnes.
Gastmans, Chris. 1998 An adjusted version of Kohlberg's moral theory: discussion of its validity for research in nursing ethics. **Journal of Advanced Nursing**. 27, pp. 820-835.
- Dilthey, Wilhelm. 1961 **Patterns and Meanings in History: Thoughts on History and Society**. Harper and Row, New York. (Cited in: Adler and Adler, 1994)
- Dimond, Bridgit. 2002 **Legal Aspects of Nursing**. 3rd ed. Longman, Harlow.
- Edwards, J. C. 1982 **Ethics without philosophy: Wittgenstein and the moral life**. University Presses of Florida, Tampa.
- Edwards, Steven. D. 1996 **Nursing Ethics: A Principled-Based Approach**. Macmillan Press, London.
- Felton, Gwen. M.
Parsons, Mary. Ann. 1987 The Impact of Nursing Education on Ethical/Moral Decision Making. **Journal of Nursing Education**. 26 (1) pp. 7-11.
- Fetterman, David. M. 1998 **Ethnography - Step by Step**. 2nd ed. Sage Publications. Thousand Oaks, California.
- Fontana, Andrea.
Frey, James. H. 2000 Interviewing – The Art of Science. In: Denzin, Norman. K. and Lincoln, Yvonna. S. (Eds.) **Handbook of Qualitative Research**. 2nd ed. Sage Publications, Thousand Oaks.
- Foucault, Michel. 1973 **The Birth of the Clinic: An Archaeology of Medical Perception**. Tavistock, London.
- Foucault, Michel. 1977 **Discipline and Punish: The Birth of the Prison**. Penguin Books, London.
- Foucault, Michel. 1978 **The Will to Knowledge – The History of Sexuality:1**. Penguin Books, London.
- Foucault, Michel. 1980 **Power/Knowledge**. Gordon, Colin. (Ed.) Harvester Wheatsheaf, New York.
- Foucault, Michel. 1997 The ethics of the concern of self as a practice of freedom. In: Rabinow, Paul. (Ed.) **Michel Foucault – ethics – essential works of Foucault 1954-1984**, volume 1. Penguin Books, London.
- Fox, Nicolas. J. 1992 **The Social Meaning of Surgery**. Open University Press, Buckingham.

- | | | |
|-----------------------------------|------|--|
| Fox, Nicolas. J. | 1993 | Postmodernism, Sociology and Health. Open University Press, Buckingham. |
| Freundlieb, Dieter. | 1994 | Foucault's Theory of Discourse and Human Agency. In: Jones, Colin. and Porter, Roy. (Eds.) 1994 Reassessing Foucault – Power, Medicine and the Body. Routledge, London. |
| Friedman, Marilyn. | 1993 | Beyond Caring: The De-Moralization of Gender. In: Larrabee, Mary. Jeanne. (Ed.) An Ethic of Care: Feminist and Interdisciplinary Perspectives. Routledge, New York. |
| Gallagher, Ursula.
Boyd, K. M. | 1991 | Teaching and Learning Nursing Ethics. Scutari Press, London. |
| Gee, J. P. | 1985 | The narrativization of experience in the oral style. Journal of Education , 167 (1) pp. 9-35. (Cited in: Riessman, 1993) |
| Gee, J. P. | 1986 | Units in the production of narrative discourse. Discourse Processes . 9, pp. 391-422. (Cited in: Riessman, 1993) |
| Gee, J. P. | 1981 | A linguistic approach to narrative. Journal of Narrative and Life History . 1 (1) pp. 15-39. (Cited in: Riessman, 1993) |
| Gibbard, Allan. | 1990 | Wise Choices, Apt Feelings – A theory of Normative Judgment. Harvard University Press, Cambridge, Massachusetts. |
| Giddens, Anthony. | 1984 | The Constitution of Society – Outline of the Theory of Structuration. Polity Press, Cambridge. |
| Gilligan, C. | 1982 | In a different voice: Psychological Theory and Women's Development. Harvard University Press, Cambridge, Massachusetts. |
| Gilligan, C. | 1993 | Reply to Critics. In: Larrabee, Mary. Jeanne. (Ed.) An Ethic of Care: Feminist and Interdisciplinary Perspectives. Routledge, New York. |
| Gillon, Raanan. | 1986 | Philosophical Medical Ethics. John Wiley & Sons, Chichester. |
| Gillon, Raanan. | 1994 | Principles of Health Care Ethics. John Wiley & Sons, Chichester. |

- | | | |
|--|------|---|
| Glaser, Barney. E.
Strauss, Anselm. L. | 1967 | The Discovery of Grounded Theory. Aldine Publishing Company, New York. |
| Gold, Carrol.
Chambers, Jewell.
McQuaid Dvorak,
Eileen. | 1995 | Ethical Dilemmas in the Lived Experience of Nursing Practice. Nursing Ethics. 2 (2) pp. 131-142. |
| Grills, Scott. | 1998 | Doing Ethnographic Research: Fieldwork Settings. Sage Publications, Thousand Oaks. |
| Grundstein-Amado,
R. | 1993 | Ethical decision-making processes used by health care providers. Journal of Advanced Nursing. 18, pp. 1701-1709. |
| Guba, Egon. G.
Lincoln, Yvonna. S. | 1994 | Competing Paradigms in Qualitative Research. In: Denzin, Norman. K. and Lincoln, Yvonna. S. (Eds.) Handbook of Qualitative Research. Sage Publications, Thousand Oaks. |
| Hammersley, Martyn. | 1989 | The Dilemma of Qualitative Method – Herbert Blumer and the Chicago Tradition. Routledge, London. |
| Hammersley, Martin.
Atkinson, Paul. | 1995 | Ethnography – Principles in Practice. 2 nd ed. Routledge, London. |
| Hegel, G. W. F. | 1967 | Philosophy of Right. Knox, T. M. (translator) Oxford University Press, London. |
| Hilton, A. | 1987 | The Ethnographic Perspective. Module 7. Research Awareness. Distance Learning Centre, South Bank Polytechnic, London. (Cited in: Mackenzie, 1994) |
| Hirschman, Albert. O. | 1970 | Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States. Harvard University Press, Cambridge, MA. |
| Holly, Cheryl.
Malahan. | 1993 | The Ethical Quandaries of Acute Care Nursing Practice. Journal of Professional Nursing. 9 (2) pp. 110-115. |
| Holm, Søren. | 1994 | American bioethics at the crossroads. European Philosophy of Medicine and Health Care. 2 (2) pp. 6-23. |

- | | | |
|---------------------------------------|-------|---|
| Holm, Søren. | 1995a | Not just autonomy – the principles of American biomedical ethics. Journal of Medical Ethics . 21, pp. 332-338. |
| Holm, Søren. | 1995b | The medical hierarchy and perceived influence on technical and ethical decisions. Journal of Internal Medicine . 237, pp. 487-492. |
| Holm, Søren. | 1997 | Ethical problems in clinical practice – The ethical reasoning of health care professionals . Manchester University Press, Manchester. |
| Jecker, Nancy. S.
Self, Donnie. J. | 1991 | Separating care and cure: an analysis of historical and contemporary images of nursing and medicine. Journal of Medical Philosophy . 16, pp. 285-306. |
| Jefferson, Gail. | 1979 | Sequential Aspects of Storytelling in Conversation. In: Schenkein, J. (Ed.) Studies in the Organization of Conversational Interaction pp. 219-248. Academic Press. New York. |
| Johnstone, Megan-Jane. | 1999 | Bioethics – a nursing perspective . 3 rd ed. Harcourt Saunders, Sydney. |
| Jones, Colin.
Porter, Roy. | 1994 | Reassessing Foucault – Power, Medicine and the Body . Routledge, London. |
| Kant, Immanuel. | 1948 | Groundwork of the Metaphysic of Morals . Translated and analysed by H. J. Paton. Routledge, London. |
| Ketefian, Shake. | 1988 | Moral Reasoning and Ethical Practice in Nursing: An Integrative Review . National League of Nursing, New York. |
| Kohlberg, Lawrence. | 1969 | Stage and Sequence: The Cognitive Developmental Approach to Socialization. In: Goslin, David. A. (Ed.) Handbook of Socialization Theory and Research . pp. 347-480. Rand McNally and Company, Chicago. |
| Kohlberg, Lawrence. | 1981 | The Philosophy of Moral Development: Moral Stages and the Idea of Justice . Harper & Row, San Francisco. |
| Labov, William. | 1972 | The Transformation of Experience in Narrative Syntax. In: Labov, W. (Ed.) Language in the Inner City: Studies in the Black English Vernacular . pp. 354-396. University of Pennsylvania Press, Philadelphia. |

- Labov, William. 1982 Speech actions and reactions in personal narrative. In: Tannen, D. (Ed.) **Analyzing Discourse: Text and Talk**. pp. 219-247. Georgetown University Press. Washington, DC.
- Labov, William. 1967 Narrative analysis: Oral Versions of Personal Experience. In: Helm, J. (Ed.) **Essays on the Verbal and Visual Arts**. pp. 12-44. University of Washington Press. Seattle.
- Liaschenko, Joan. 1998 The shift from the closed to the open body – ramifications for nursing testimony. In: Edwards, Steven. B. (Ed.) **Philosophical Issues in Nursing**. Macmillan, Houndmills.
- Lincoln, Yvonna. S. 1994 The Fifth Movement. In: Denzin, Norman. K. and Lincoln, Yvonna. S. (Eds.) **Handbook of Qualitative Research**. Sage Publications, Thousand Oaks.
- Lincoln, Yvonna. S. 1985 **Naturalistic Inquiry**. Sage Publications, Newbury Park.
- Lundquist, L. 1988 **Byråkratisk Etik**. Studentlitteratur, Lund. (Cited in: Holm, 1995b)
- Lützén, Kim. 1993 Benevolence, a central moral concept derived from a grounded theory study of nursing decision making in psychiatric settings. **Journal of Advanced Nursing**. 18, pp. 1106-1111.
- Lützén, Kim. 1995 Moral Sensitivity in Nursing Practice. **Scandinavian Journal of Caring Science**. 9, pp. 131-138.
- Lützén, Kim. 1996 The Role of Virtue Ethics in Psychiatric Nursing. **Nursing Ethics**. 3 (3) pp. 202-211.
- Lützén, Kim. 1997 Nursing Ethics Into the Next Millennium: a context-sensitive approach for nursing ethics. **Nursing Ethics**. 4 (3) pp. 218-226.
- Lützén, Kim. 1997 Moral Sensitivity in Psychiatric Practice. **Nursing Ethics**. 4 (6) pp. 472-482.
- Evertzon, Mats. Nordin, Conny.

- | | | |
|---|------|---|
| Lyotard, Jean-Francois. | 1984 | The Postmodern Condition: A Report on Knowledge. Manchester University Press. Manchester. |
| MacIntyre, Alasdair. | 1966 | A Short History of Ethics – A History of Moral Philosophy from the Homeric Age to the Twentieth Century. Routledge, London. |
| MacIntyre, Alasdair. | 1985 | After Virtue – a study in moral theory. 2 nd ed. Duckworth, London. |
| Mackay, Lesley. | 1989 | Nursing a Problem. Open University Press, Milton Keynes. |
| Mackenzie, Ann. E. | 1994 | Evaluating ethnography: considerations for analysis. Journal of Advanced Nursing. 19, pp. 774-781. |
| Manning, Peter. K.
Cullum-Swan, Betsy. | 1994 | Narrative, Content and Semiotic Analysis. In: Denzin, Norman. K. and Lincoln, Yvonna. S. (Eds.) Handbook of Qualitative Research. Sage Publications, Thousand Oaks. |
| Mappes, Thomas. A.
DeGrazia, David. | 2001 | Biomedical Ethics. 5 th ed. McGraw-Hill, New York. |
| Massarik, Fred. | 1981 | The interviewing process re-examined. In: Reason, Peter. and Rowan, John. (Eds.) Human Inquiry – A Sourcebook of New Paradigm Research. John Wiley & Sons. Chichester. |
| May, C. | 1992 | Individual care? Power and subjectivity in therapeutic relationships. Sociology. 26 (4) pp. 589-602. |
| May, W. F. | 1994 | The virtues in a professional setting. In: Fulford, K. W. M., and Gillet, Grant. and Soskice, Janet. Martin. (Eds.) Medicine and Moral Reasoning. Cambridge University Press, Cambridge. |
| Measor, Lynda. | 1985 | Interviewing: a Strategy in Qualitative Research. In: Burgess, Robert. G. Strategies of Educational Research: Qualitative Methods. The Falmer Press, Barcombe. |
| Michaels, Sarah. | 1981 | “Sharing time”: Children’s narrative styles and differential access to literacy. Language and Society. 10, pp. 423-442. |

- Miers, Margaret. 1999 Nursing teams and hierarchies: nurses working with nurses. In: Wilkinson, Geoff. and Miers, Margaret. (Eds.) **Power and Nursing Practice**. Macmillan, Houndmills.
- Miles, Matthew. B. 1994 **Qualitative Data Analysis**. 2nd ed. Sage Publications, Thousand Oaks.
- Huberman, A. Michael.
- Mill, John. Stuart. 1990 Higher and Lower Pleasures. In: Glover, Jonathan. (Ed.) **Utilitarianism and Its Critics**. Macmillan Publishing Company, New York.
- Mishler, Elliot. G. 1991 Representing Discourse: The Rhetoric of Transcription. **Journal of Narrative and Life History**. 1 (4) pp. 255-280.
- Morse, Janice. M. 1992 Exploring Empathy: A Conceptual Fit for Nursing Practice? **Image: Journal of Nursing Scholarship**. 24 (4) pp. 273-280.
- Anderson, Gwen.
- Bottoroff, Joan. L.
- Yonge, Olive.
- O'Brien, Beverley.
- Solberg, Shirley. M.
- Hunter McIlveen, Kathleen.
- Mowforth, Gill. 1999a Elitism in nursing. In: Wilkinson, Geoff. and Miers, Margaret. (Eds.) **Power and Nursing Practice**. Macmillan, Houndmills.
- Mowforth, Gill. 1999b Power, gender and nursing work. In: Wilkinson, Geoff. and Miers, Margaret. (Eds.) **Power and Nursing Practice**. Macmillan, Houndmills.
- Murray, Thomas. H. 1994 Medical ethics, moral philosophy and moral tradition. In: Fulford, K. W. M., and Gillet, Grant. and Soskice, Janet. Martin. (Eds.). **Medicine and Moral Reasoning**. Cambridge University Press, Cambridge.
- Norberg, A. 1995 Gender Differences in Moral Reasoning Among Physicians, Registered Nurses and Enrolled Nurses Engaged in Geriatric and Surgical Care. **Nursing Ethics**. 2 (3) pp. 233-241.
- Uden, G.
- Oddi, Lorys. F. 1995 Nurses' Sensitivity to the Ethical Aspects of Clinical Practice. **Nursing Ethics**. 2 (3) pp. 197-209.
- Cassidy, Virginia. R.
- Fisher, Cheryl.
- Parker, R. S. 1990 Measuring Nurses' Moral Judgements. **Image: Journal of Nursing Scholarship**. 22 (4) pp. 213-218.

- | | | |
|--|------|--|
| Patton, Michael.
Quinn. | 1987 | How to Use Qualitative Methods in Evaluation. Sage Publications, Newbury Park. |
| Porter, Sam. | 1998 | Social Theory and Nursing Practice. Macmillan Press, London. |
| Punch, Maurice. | 1994 | Politics and Ethics in Qualitative Research. In: Denzin, Norman K. and Lincoln, Yvonna S. (Eds.) Handbook of Qualitative Research. Sage Publications, Thousand Oaks. |
| Rest, J. | 1986 | DIT Manual - Manual for the Defining Issues Test. 3 rd ed. University of Minnesota Press, Minneapolis. |
| Reynolds, William. J. | 2000 | The Measurement and Development of Empathy in Nursing. Ashgate Publishing Ltd. Aldershot. |
| Richardson, Laurel. | 2000 | Writing: A Method of Inquiry. In: Denzin, Norman. K. and Lincoln, Yvonna. S. (Eds.) Handbook of Qualitative Research. 2 nd ed. Sage Publications, Thousand Oaks. |
| Rickard, Maurice.
Kuhse, Helga.
Singer, Peter. | 1996 | Caring and Justice: A study of two approaches to health care ethics. Nursing Ethics. 3 (3) pp. 212-223. |
| Riessman, Catherine.
Kohler. | 1993 | Narrative Analysis. Sage Publications, Newbury Park. |
| Roberts, Susan. Jo. | 1983 | Oppressed group behaviour: implications for nursing. Advances in Nursing Science. 5 (4) pp.21-30. |
| Rosenstand, Nina. | 1994 | The Moral of the Story – An Introduction to Questions of Ethics and Human Nature. Mayfield Publishing Company, Mountain View. |
| Rumbold, Graham. | 1999 | Ethics in Nursing Practice. 3 rd ed. Baillière Tindall, Edinburgh. |
| Sartre, Jean Paul. | 1948 | Existentialism and Humanism. Methuen & Co. Ltd, London. |
| Sartre, Jean Paul. | 1958 | Being and Nothingness. Routledge, London. |
| Scott, P. Anne. | 1995 | Aristotle, Nursing and Health Care Ethics. Nursing Ethics. 2 (4) pp. 279-285. |

- Scott, P. Anne. 1996 Ethics Education and Nursing Practice. **Nursing Ethics**. 3 (1) pp. 53-63.
- Seedhouse, David. 1998 **Ethics: The Heart of Health Care**. 2nd ed. John Wiley & Sons, Chichester.
- Seedhouse, David. 2000 **Practical Nursing Philosophy – The Universal Ethical Code**. John Wiley & Sons, Ltd, Chichester.
- Sherblom, Stephen. 1993 Justice, Care and Integrated Concerns in the Ethical Decision Making of Nurses. **Qualitative Health Research**. 3 (4) pp. 442-464.
- Shipps, Theresa. B. 1992 **No Longer Patient: Feminist Ethics and Health Care**. Temple University Press, Philadelphia.
- Sherblom, John. C.
- Sidgwick, Henry. 1994 The Axioms of Ethics. The Methods of Ethics. 7th ed. Macmillan, London. In: Singer, Peter (Ed.) 1994. **Ethics**. Oxford Readers. Oxford University Press, Oxford.
- Silverman, David. 1985 **Qualitative Methodology and Sociology: Describing the Social World**. Gower Publishing Group, Aldershot.
- Sim, Stuart. 1998 Postmodernism and Philosophy. In: Sim, Stuart. (Ed.) **The Icon Critical Dictionary of Postmodern Thought**. Icon Books, Cambridge.
- Singleton, Jane. 1995 **Ethical Foundations of Health Care**. Mosby, London.
- McLaren, Susan.
- Smith, Katharine. 1996 Ethical Decision-Making by Staff Nurses. **Nursing Ethics**. 3 (1) pp. 17-25.
- Vogel.
- Smith, Pam. 1992 **The Emotional Labour of Nursing – Now nurses care**. Macmillan, Houndmills.
- Solomon, Robert. C. 1972 **From Rationalism to Existentialism – The Existentialists and Their Nineteenth-Century Backgrounds**. Littlefield Adams Quality Paperbacks. Lanham, Maryland.
- Spradley, James. P. 1979 **The Ethnographic Interview**. Holt, Rinehart and Winston, New York.
- Steier, Frederick. 1991 **Research and Reflexivity**. Sage Publications, London.

- Stein, Leonard. 1978 The doctor – nurse game. In: Dingwall, Robert. and McIntosh, Jean. (Eds.) **Readings in the Sociology of Nursing**. Churchill Livingstone, Edinburgh.
- Strauss, Anselm. 1990 **Basics of qualitative Research – Grounded Theory, Procedures and Techniques**. Sage Publications, Newbury Park.
- Corbin, Juliet.
- Thompson, Ian. E. 2000 **Nursing Ethics**. 4th ed. Churchill Livingstone, Edinburgh.
- Melia, Kath. M.
- Boyd, Kenneth. M.
- Tadd, Win. 1994 Ethics in the Curriculum. In: Tschudin, V. (Ed.) **Ethics Education and Research**. Scutari Press, London.
- Taylor, Stephanie. 2002 **Ethnographic Research: A Reader**. Sage Publications, London.
- The Concise Oxford Dictionary. 1995 9th ed. Della Thompson (Ed.) Clarendon Press, Oxford.
- Toulmin, Stephen. 1981 The Tyranny of Principles. **The Hastings Center**. December, pp. 31-9.
- Trivers, Robert. 1994 The Evolution of Reciprocal Altruism. In: Singer, Peter. (Ed.) **Ethics**. Oxford University Press, Oxford.
- Udén, Giggi. 1992 Ethical reasoning in nurses' and physicians' stories about care episodes. **Journal of Advanced Nursing**. 17, pp. 1028-1034.
- Norberg, Astrid.
- Lindseth, Anders.
- Marhaug, Venke.
- UKCC. 1992 **Code of Professional Conduct**. 3rd ed. United Kingdom Central Council.
- Vidich, Arthur. J. 1998 Qualitative Methods: Their History in Sociology and Anthropology. In: Denzin, Norman. K. and Lincoln, Yvonne. S. (Eds) **The Landscape of Qualitative Research: Theories and Issues**. Sage Publications, Thousand Oaks.
- Lyman, Stanford. M.
- Weber, M. 1948 **From Max Weber: Essays in Sociology**. Gerth, H. H. and Mills, C. Wright. (Eds. and Trans.) Routledge & Kegan Paul, London.
- Wilkinson, Geoff. 1999 Theories of power. In: Wilkinson, Geoff. and Miers, Margaret. (Eds.) **Power and Nursing Practice**. Macmillan, Houndmills.

- | | | |
|--------------------------------|------|---|
| Wilkinson, Judith. M. | 1987 | Moral Distress in Nursing Practice: Experience and Effect. Nursing Forum . 23 (1) pp. 16-29. |
| Wittgenstein, L. | 1958 | Philosophical Investigations . Basil Blackwell, Oxford. |
| Wittgenstein, L. | 1965 | A lecture on ethics. Philosophical Review . 74, January, pp. 3-12. |
| Witz, Anne.
Savage, Mike. | 1992 | The gender of organisations. In: Savage, Mike. and Witz, Anne. (Eds.) Gender and Bureaucracy . Blackwell Publishers, Oxford. |
| Young, Katharine.
Galloway. | 1987 | Taleworlds and Storyrealms: The Phenomenology of Narrative . Martinus Nijhoff Publishers, Dordrecht. |

APPENDICES

APPENDIX 1

PARTICIPANTS

Gerri	newly qualified staff nurse
Hilary	sister/charge nurse
Jane	sister/charge nurse
Kerry	sister/charge nurse
Lucy	newly qualified staff nurse
Mandy	newly qualified staff nurse
Nicky	newly qualified staff nurse
Pat	newly qualified staff nurse
Quincy	sister/charge nurse
Rebecca	staff nurse
Sally	staff nurse
Tina	sister/charge nurse
Ursula	sister/charge nurse
Val	staff nurse
Winny	sister/charge nurse
Xaria	newly qualified staff nurse
Yvonne	sister/charge nurse
Zoe	staff nurse

Please note:

The above is a list of nurses who participated in this study by talking about their experiences. Most, but not all, are cited in the content of this study. For purposes of confidentiality details of participants have been kept to a bare minimum.

APPENDIX 2

GLOSSARY OF ABBREVIATIONS AND TERMS USED BY NURSES

ALS	Advanced Life Support
Angio(s)	Angiography or Angiogram(s)
BM(s)	Registered trademark for blood sugar level monitoring sticks
Bypass	Bypass graft or bypass surgery (“double” or “triple” bypass refers to the number of coronary grafts performed during surgery)
Cabbage	Coronary Artery Bypass Graft
CD drug	Controlled Drug
Chemo	Chemotherapy
CVS	Cardio-Vascular System
DC shock	Direct Current shock
DNAR	Do Not Attempt Resuscitation
GP	General Practitioner
HDU	High Dependency Unit
ICU or ITU	Intensive Care Unit or Intensive Therapy Unit
IV(s)	Intravenous infusion(s)
NHS	National Health Service
Obs	Clinical observations (usually, blood pressure, pulse rate, respiratory rate and temperature)
OT	Occupational Therapist
PEG	Percutaneous Endoscopic Gastrostomy
Physio(s)	Physiotherapist(s)
Post-op	Post-operation
Pre-med(s)	Pre-medication(s)

Radio	Radiotherapy
Reg(s)	Registrar(s)
Rehab	Rehabilitation
Resus	Resuscitation
SHO(s)	Senior House Officer(s)
TED(s)	Registered trade mark for anti-embolism stockings
Trachy	Tracheostomy
TTA(s)	To Take Away – patient discharge medication(s)
U&Es	Urea and Electrolytes
Venflon	Proprietary name for an intravenous canular

APPENDIX 3

SEMI-STRUCTURED, FOCUSED INTERVIEW SCHEDULE

- **Explanation and the seeking of interviewee consent**
- Give information about the interview (what it entails, how long it is likely to last, its purpose – to enquire about the ethical reasoning and decision-making of the interviewee, etc.)
- Ensure that the interviewee fully understands the nature of his or her involvement and ask him or her to sign the consent form
- **Introductory remarks (once consent is given)**
- Thank interviewee for participating
- Explain that I am not seeking ‘right’ answers – I am interested in the views and experiences of the interviewee
- Explain why the interviewee is being audio-tape recorded and allay any concerns the interviewee might have (explain that I will turn the recorder off at any time if they wish me to)
- Explain that during the interview I may take written notes
- **Initial ‘warm up’ questions** – “How long have you been nursing on this ward?” “What past clinical experience have you had?” “How long have you been qualified as a nurse?” “Where did you undertake your training?”
- **Broad topic areas to be covered during the interview include:**
- Identification of incidents/issues/ topics which the interviewee has found ethically difficult
- Exploration of the ethical nature and difficulties inherent in the incidents/issues/topics identified
- Exploration of options available and decisions made (with particular emphasis on the reasoning behind decisions made)
- Identification of both positive and negative influencing factors (e.g. professional, institutional, cultural and environmental)
- Identification of factors which would have been helpful
- It is not possible to anticipate the entire content of the interview because the content is to some extent dependent on what is raised by the interviewee
- **Ending the interview**
- Offer the interviewee the opportunity to reflect and ask if he or she has anything else to add
- Thank interviewee for participating
- **Inform the interviewee that they will shortly receive a copy of the transcription and ask if they would read it and verify its accuracy**

APPENDIX 4

CONSENT FORM

WRITTEN CONSENT FORM:

Title of research proposal: EXAMINATION OF THE MORAL REASONING AND ETHICAL DECISION-MAKING OF NURSES IN PROFESSIONAL PRACTICE

Name of Patient/Volunteer (Block Capitals):

REC

Number:

Address:

- The study organisers have invited me to take part in this research. —
- I understand what is in the leaflet about the research. I have a copy of the leaflet to keep. —
- I have had the chance to talk and ask questions about the study. —
- I know what my part will be in the study and I know how long it will take. —
- I know how the study may affect me. —
I have been told if there are possible risks. —
- I understand that I should not take part in more than one study at a time. —
- I know that the local (...deleted...) Health Authority Research Ethics Committee has seen and agreed to this study. —
- I understand that personal information is strictly confidential: I know the only people who may see information about my part in the study are the research team. —
- I freely consent to be a subject in the study. No-one has put pressure on me. —
- I know that I can stop taking part in the study at any time. —
- I know that if there are any problems, I can contact: —

Mr Cliff Chaplin

Tel. No. (...deleted...)

Patient's/Volunteer's: Signature

Witness's Name

Witness's Signature:

Date

The following should be signed by the Investigator responsible for obtaining consent.

As the Investigator responsible for this research or a designated deputy, I confirm that I have explained to the patient/volunteer named above the nature and purpose of the research to be undertaken.

Investigator's Name:

Investigator's Signature: Date:

APPENDIX 5

INFORMATION LEAFLET

EXAMINATION OF THE MORAL REASONING AND ETHICAL DECISION- MAKING OF NURSES IN PROFESSIONAL PRACTICE

Information to Participate in a Research Project

I invite you to take part in a research study which I think may be important. It is important that you understand what is in this leaflet. It says what will happen if you take part. Try to make sure you know what will happen to you if you decide to take part. Whether or not you do take part is entirely your choice. Please ask any questions you want to about the research and I will try my best to answer them.

As a nurse practising in the Cardiac Services Unit I am interested to know about the ethical situations you may face, what your thoughts are and how you make decisions relating to such situations.

If you agree to take part in this research study I would like to interview you. The interview will take place at a mutually agreed time and place, will be audio-taped and will last about an hour. With your agreement further interviews may be arranged. The audio-taped interview will be transcribed and you will be sent a copy of the transcription in order to verify its accuracy. Your confidentiality will be protected. The transcriptions will be coded, will not refer to you by name and there will be no identifying reference to you in publications resulting from the study. Only myself and my research supervisor will have access to uncoded records relating to the study. Special care will be taken to ensure confidentiality relating to computerised records resulting from this study.

If you agree to take part it is hoped that you find participation a rewarding and reflective experience. It is hoped that the findings will not only add to our knowledge in this field but most importantly will be helpful in ensuring ethical nursing care.

You don't have to join the study. You are free to decide not to be in this research study or to drop out at any time.

If you become worried or concerned about participation in this research study you will be able to contact the investigator to discuss your concerns:

Name: Cliff Chaplin
Address: (...deleted...)
Telephone number: (...deleted...)

APPENDIX 6

RESEARCH NOTIFICATION

Dear Colleagues,

The purpose of this notification is to inform you that I am conducting research in this clinical area.

The research is part of a PhD study and is entitled: Examination of the moral reasoning and ethical decision-making of nurses in professional practice.

I hope to start the process of data collection shortly and expect this process to last for some time, possibly as long as a year.

The study will be ethnographic and data collection will involve me taking part in and observing nursing practice.

I will endeavour to keep you updated regarding the progress of the study.

Finally, if you have any questions about the research or any concerns please feel free to contact me.

Cliff Chaplin
Researcher

APPENDIX 7

AN EXAMPLE TO ILLUSTRATE OPEN CODING AND INITIAL CATEGORISING USING WINNY'S INTERVIEW TRANSCRIPTION

PERSONAL/INDIVIDUAL NURSE

- Belittling – accused of making a fuss about nothing – she wanted doctors to document a ‘not for resuscitation’ decision (W142)
- Personal feelings re. situation – without documentation, having to resus a dying man (W164)
- ‘Golden rule’ – if it were my relative (W206)
- Dealing with the angry patient and not taking the patient’s anger personally (W378)
- Emotional involvement with patient’s ordeal as he waits for heart transplant (W398) (W425) (W431)
- Not getting all emotional yourself – got a job to do (W440)
- At the end of the day you go home – not your relative – need to be strong (W462)
- Need for tactfulness in dealing with doctors and wound assessment (W647)
- Strongly felt duty to speak up (W677)
- Reflection (W740) and experience (W748) – this discussion has been interesting as it has allowed reflection (W791)
- Ethical sensitivity and taking ethical responsibility – “personally no” I do not face ethical problems (W49) – few problems in ethical decision-making (W272) – face difficult decisions but not ethical decisions (W490) – same with other nurses (W284)

SIGNIFICANT EVENTS AND ISSUES

- Resuscitation – doctors not writing resuscitation decisions in the patients notes (W54)
- Late cancellation of patient surgery – not an ethical issue – maybe it is (W333) – nurses have to deal with patient upset (W348) and need to be an ear for the patient (W363)
- Relatives withdrawing donor consent at the last moment (W407)
- Early post surgical patient discharge from the ward – nurse and doctor differences (W591)
- Past clinical and ethical experience – Transplantation and limited resources (W293) – Nurse involvement with patient who died waiting for donor heart (W398)

NURSING

- Position of the nurse with respect to the law (W103)
- Role of the nurse and the need for a professional manner (W450)
- Role of the nurse – to pick up patient non-verbal cues (W693)
- Holistic care (W560) (W564)
- Psycho-social aspect of nursing care (W599)
- Being a patient advocate re. wound assessment (W665)
- Having a duty to speak up (W670) (W677)

INTER-PROFESSIONAL RELATIONS

- Consultant refusing to document 'not for resuscitation' decision (W54) – nurses never given an explanation (W157)
- Communication between nurses and doctors is good (W252) – sometimes problems, e.g. regarding documentation (W231)
- Nurses and doctors have on the whole a good working relationship (W540)
- Differences between nurses and doctors – nurses spend more time with patients (W547)
- Doctors talk of patients as “cabbages” and “valves” (W552) (W564)
- Differences regarding post-surgical patient readiness for discharge home (W611)
- Differences regarding wound assessment – doctors may feel their judgement is being questioned (W639)

ENVIRONMENT AND CONTEXT

- Hierarchical decision-making – consultant should document 'not for resuscitation' decisions (W131) – issue was discussed at high level (W179)
- Decisions often made by others but nurses are affected – for example, heart transplant decisions (W319)
- Regarding late cancellation of patient surgery – the system lets us down – there is a lack of beds in ITU (W349)
- Patient's Charter doesn't help – it gives false expectations (W379)

PATIENT, FAMILY AND FRIENDS

- Having to resuscitate the dying patient was undignified and not in the patient's best interests (W224)
- In transplantation, the difficulty of the patient who does not get the available heart seeing the patient who does (W312)
- Patients are more familiar with nurses than doctors and often call nurses by their first name (W576)
- Sensitive to patient vulnerability (W685)
- Patients feel that they do not want to waste nurse's or doctor's time (W703)

ETHICAL DECISION-MAKING

- The importance of a supportive nursing team (W477)
- Allowing nurses to get away from situations (W484)
- Being supportive, as a senior person, show that you care, be available and be a resource for people (W510)
- Encouraging people to come to you and talk things through (W517)
- Assertiveness (W644) – being democratic and assertive ((W652)
- Having experience (W711) and confidence (W721) (W808) – usefulness of experience in dealing with staff shortage (W760)
- Prioritising when there is a lack of resources (W777)
- Ethical decision-making is difficult in situations of staff shortage (W760)
- Ethical decision-making is difficult when communication between nurses and between doctors and nurses is poor (W537)

APPENDIX 8

EXAMPLE OF A CATEGORISED COMPOSITE

MAIN CATEGORY – THE NURSE

**SUB-CATEGORY – IDENTIFICATION OF SIGNIFICANT ETHICAL
EVENTS AND ISSUES**

Resuscitation

- “Wishy-washy decision-making regarding ‘not for resuscitation’ decisions (U67)
- Doctors not writing resuscitation decisions in patients notes (W54)
- Incident where doctors refused to document a ‘not for resuscitation’ decision on a young man (Z178)(Q189)
- Incident where doctors took no account of patient’s wish not to be resuscitated – nurses had to resuscitate if necessary (X400)
- The unwritten policy – doctors not putting anyone ‘not for resuscitation’ – incident of the terminally ill woman who was dying and still for resuscitation (G47) (L140) - the dying patient was transferred to another ward where she died twenty minutes later ((L176)
- Having to resuscitate the terminally ill (M87)

Late cancellation of patient surgery

- Not an ethical issue – maybe it is (W333)
- Occurs commonly – “Hundreds on a daily basis” (Y255)
- Nurses have to deal with patient upset (W348) and need to be an ear for the patient (W363)
- Nurses have to inform the patient (R57) – it is almost a lie (R82) and may involve the loss of patient trust (R94&108)
- Potentially harmful – patient not psychologically prepared next time (R103)
- Informing the patient in order that they can eat (P192)
- Reason for cancellation not always given to ward staff who then are unable to inform patient (P350)
- Incident where a young woman died having been cancelled three times – her place on the theatre operating list was given to a patient whose family “created and stink” (Q59)
- The effect – violent patient reaction(L530) (P334)
- The psychological effect of cancelled surgery on the patient (M300)
- Unfair priority given to patients who are doctors (L305)
- Patients take cancellation of surgery “in their stride a bit more now” (N283)
- Cancellation of surgery because of a lack of ITU beds (P251)
- “It is very political” (L484)

Early post-surgical patient discharge

- Inappropriate early discharge to convalescence (S476)
- Early discharge from the ward – nurse and doctor differences (W591)

- Nurses tried to be organisationally more pro-active (U258)
- The patient who was scared to go home (V183)

Lack of resources

- Being short-staffed (U177)
- Unsafe practice due to shortage of staff (H84)
- Being short-staffed leads to high work-loads and nurses become short-tempered (J443)
- Lack of experience staff (H226)
- Being short-staffed and the lack of support for new and newly qualified nurses (L44)
- Problems of ward management when short-staffed (N82)

Prescribing medications

- The patient in pain (doctors failed to prescribe adequate pain relief) (T76)
- Doctors failing to prescribe night sedation for anxious patients (L421)
- The patient prescribed Dopamine and Lasix (V63)

Wound Care

- Refusing to administer prescribed Betadine wound irrigation (J610) (N216)(P167)
- Wound care – doing what is best for the patient rather than carrying out doctor's instructions (P54&148)

Death and dying

- Caring for the terminally ill patient on HDU (U488)
- Having to transfer to another hospital a patient who death was imminent (U666)
- The unexpected death of a young patient (S41)
- The anaesthetist using the body as a teaching tool (S198)

Information giving and consent

- Patient not fully informed regarding cancer diagnosis and poor prognosis (T280)
- Thoracic patients kept waiting regarding information about their diagnosis and prognosis (G284)
- Informed consent – patients' lack of understanding (J70)
- Doctors instruct nurses not to inform patient or relatives of surgical mistakes in theatre (K111)

Others

- The surgeons audit meeting – injustice – prejudicial selection of patients to manufacture "success" rate (S679)
- The removal of a patients chest drain against the nurse's better judgement after being instructed to do so (R195)
- Being disciplined for arguing with a patient (V313)
- Prioritising care with little experience (X53)
- Poor working relations between different teams of doctors (J584) – doctors having a "slanging match" in the corridor (J671)
- The doctor who "accused me of killing a patient" (Q485)

- Experienced nurses identify ethical issues rather than events (U805)

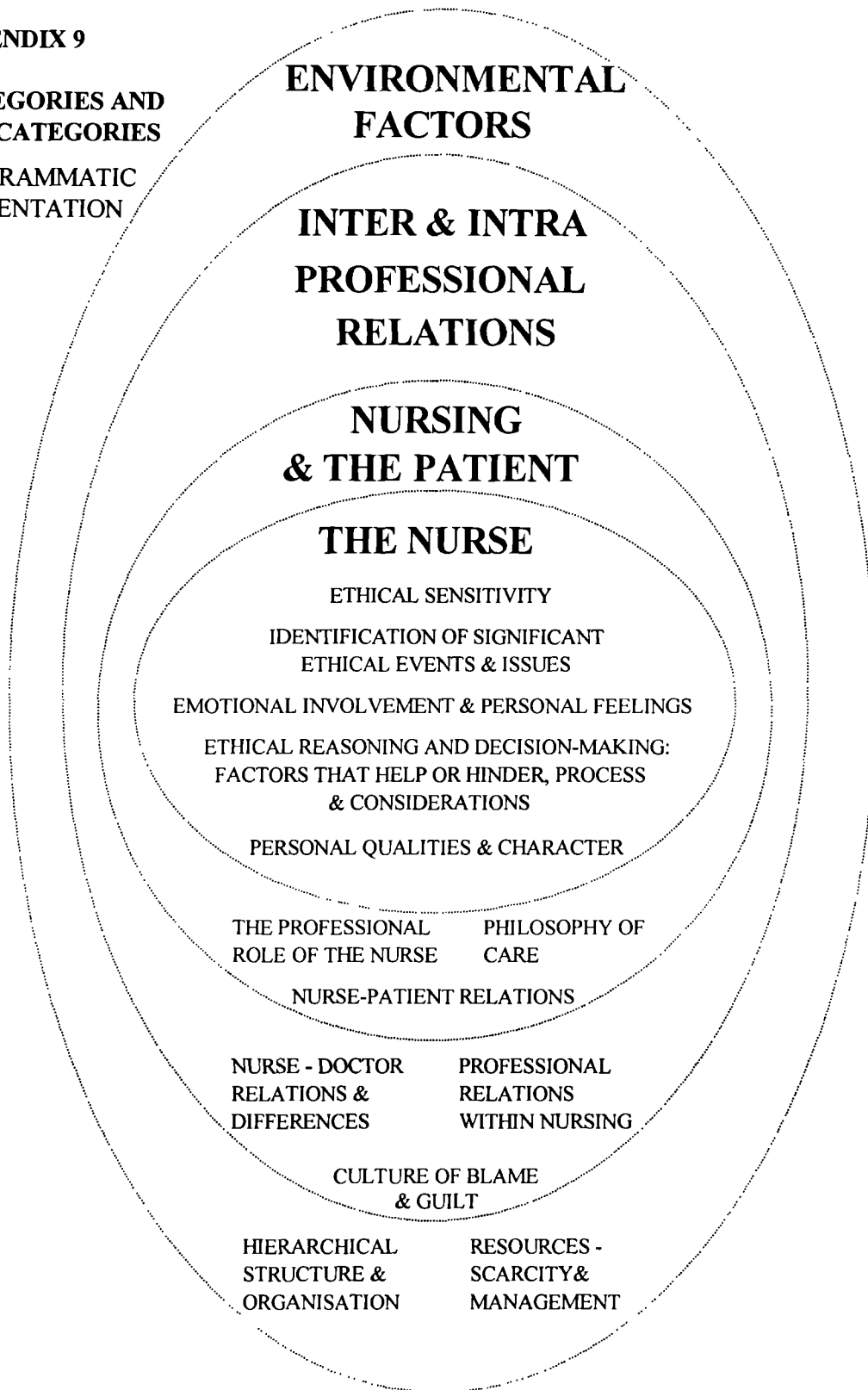
Past experiences

- Past clinical and ethical experience – transplantation and limited resources (W293) – nurse involvement with patient who died waiting for donor heart (W398)
- Relatives withdrawing donor consent at the last moment (W407)
- The obese patient who died (J216)

APPENDIX 9

**CATEGORIES AND
SUB-CATEGORIES**

**DIAGRAMMATIC
PRESENTATION**



20 May, 2000

APPENDIX 10

SUMMARY OF CATEGORIES, SUB-CATEGORIES AND THEIR DIMENSIONAL PROFILES

As a result of data analysis four categories emerged: **The Nurse, Environmental factors, Inter and Intra-Professional Relations, and Nursing and the Patient**. Each category has respective sub-categories. The category of **The Nurse** emerged from the four main categories as the core category.

THE NURSE

This category is concerned with the individual nurse. Clearly the nurse existed within the context of the three other categories. As a result, certain aspects of this category overlap with themes in other categories. Five sub-categories emerge: **Ethical Sensitivity, Identification of Significant Ethical Events and Issues, Emotional Involvement and Personal Feelings, Ethical reasoning and decision-making: Factors that Help or Hinder, Process and Considerations and Personal Qualities and Character**.

Ethical Sensitivity: This sub-category is concerned with the degree to which the nurse was aware of the ethical nature of professional practice.

- High degree of ethical sensitivity - all nurses interviewed could identify ethical events or issues
- Some ethical events were profound and had a long lasting effect on the nurse
- Nurses suggested they were involved in difficult ethical situations daily and perhaps much more than they themselves realised
- As the nurse became more experienced he or she identified ethical issues rather than events
- Applying knowledge and experience was important in determining whether a problem was an ethical one or not

Identification of Significant Ethical Events and Issues: This sub-category is concerned with those events and issues experienced by nurses and identified as significant and ethical. For the purpose of this enquiry an “event” refers to a specific incident while an “issue” refers to a general topic. An issue may be illustrated by a number of events. There were three main areas where nurses were presented with ethical difficulties.

Late cancellation of patient surgery resulted from “conveyer-belt surgery” and presented the nurse with a number of ethical problems:

- Having to inform the patient that his or her surgery had been cancelled
- It became difficult for the nurse to psychologically prepare a patient for surgery after the patient had previously experienced late cancellation – patients may as a consequence suffer harm
- The nurse sometimes felt that he or she was deceiving the patient and as a consequence might lose patient trust

- Late cancellation of patient surgery was an example whereby decisions made by others (doctors and administrators) created ethical problems for the nurse

Patient discharge and discharge planning was another issue that resulted from “conveyer-belt surgery” and presented the nurse with ethical problems:

- Nurse-doctor disagreements
- Doctors prematurely discharged patients home
- Difficulties caused by premature discharge
- Nurses tried to be more proactive and lead the discharge process rather than let doctors decide
- Nurses got to know the patient well
- Premature post-cardio-thoracic surgical discharge might be harmful because the patient was not psychologically ready to go home

Resuscitation and resuscitation decisions was another area that presented nurses with ethical problems:

- Nurses were usually first on the scene when a patient had a cardiac arrest and were legally obliged to instigate resuscitation unless a “not for resuscitation” order was clearly documented by the responsible consultant or his deputy in the patient’s notes
- Nurses and doctors on occasions disagreed about the resuscitation status of a patient
- Without a documented ‘not for resuscitation’ order, nurses were unable to let terminally ill patients die with dignity

Emotional Involvement and Personal Feelings: This sub-category is closely linked with the section in the sub-category Nurse – Patient Relations on Sensitivity, Empathy and Insight into Patient Experience. It is concerned with the emotional involvement of nurses and the expression of personal feelings.

- Key terms were used to express personal feelings (e.g. “uncomfortable”, “upset”, “angry”, “frustrated”)
- Some nurses blamed themselves and felt guilty
- Some nurses had feelings of selfishness
- Some situations were emotionally difficult
- The emotional difficulty in dealing with patient anger
- Nurses experienced long-term personal effects due to exposure to significant ethical events

Ethical reasoning and decision-making: Helpful or Obstructive Factors, Process and Considerations: This sub-category has two themes. The first is concerned with those factors that help or hinder the process of ethical reasoning and decision-making.

- Nurses identified a number of **helpful factors**: Supportive team and management style, Positive role modelling, Offloading and getting away, Clinical skill and credibility, Experience (professional and personal), Being reflective (a useful and painful process), Confidence, Openness and honesty, Formal counselling, Professional nursing bodies
- Nurses identified a number of factors that **obstructed** ethical decision-making: Unsupportive team or management style, Feeling isolated and being unable to offload, Being unable to get away, Being junior and inexperienced and as yet not having developed knowledge and skill

- Other obstructive factors identified included: Differences of opinion between doctors and nurses, Breakdown in professional communications, Competitiveness between professionals, Hierarchical pressure

The second theme in this sub-category is concerned with the process and considerations involved in the ethical reasoning and decision-making of nurses. This appeared to involve applying personal philosophy, including perceptions of self and others and personal values

- Applying the so-called 'Golden Rule'
- Valuing personal duty and accountability
- Considering what was "best for the patient"
- Concern for "doing the patient no harm"
- Having a holistic perception of the patient

Personal Qualities and Character: This sub-category is concerned with the relationship between a nurse's character and how individual qualities may influence the ethical decision-making of the nurse. This sub-category is clearly closely linked to the one above relating to factors that help or hinder ethical decision-making.

- The character of senior nurses influenced management style: Being democratic and assertive, Having personal strength and a clear idea of the leadership role, Being organised and forward thinking, Being open and approachable
- Other personal qualities and character traits identified as useful in ethical decision-making included: personal strength, courage, being "bolshi" and questioning, strong-mindedness, having experience, confidence and being reflective
- There were a number of unique personality traits associated with individual nurses that might be helpful in ethical decision-making. These included for example: Seeing things in "black and white", Having friends who you can talk to, Being "prim and proper" and "old fashioned"

ENVIRONMENTAL FACTORS

Nurses, throughout the data, frequently referred to two environmental factors that caused them ethical difficulties. These environmental factors form two sub-categories: **Hierarchical Structure and Organisation** and **Resources - Management and Scarcity**.

Hierarchical Structure and Organisation: As the title suggests, this sub-category is concerned with the hierarchical nature of the structure and organisation of care and the ethical difficulties this can cause for nurses. This sub-category is clearly linked with the sub-categories found in the category Inter-Professional Relations concerned with different aspects of the nurse-doctor relationship.

- Decisions made by others, mainly doctors/surgeons, presented or caused the nurse ethical difficulties
- The hierarchically designated decision-maker (usually the doctor or surgeon) failed to carry out his or her responsibility, thereby causing difficulties for the nurse

Resources - Management and Scarcity: This sub-category is concerned with the issue of lack of resources, the ethical difficulties caused and the ways in which nurses respond. Examples and issues included:

- A lack of ITU beds caused the last minute cancellation of surgery.
- Being busy and short-staffed caused difficulties regarding prioritising care – sometimes important aspects of care were not dealt with because of higher priorities elsewhere
- Being short-staffed caused stress when nurses felt standards of care might slip and they had difficulty in maintaining a “duty of care” towards patients
- Having a professional duty to report such circumstances to management
- Patients often did not raise their problems when they perceived the ward as being busy and the nurses as stressed

INTER AND INTRA-PROFESSIONAL RELATIONS

Throughout the data there is reference to professional relations, particularly that between nurses and doctors/surgeons and that between nurses themselves. Other health care professionals are mentioned, but to a much less degree and usually in the context of a good relationship. This category and its sub-categories are clearly linked with and must be considered in relation to the first category (Environmental Factors) and its sub-categories (Hierarchical Structure and Organisation and Resources – Management and Scarcity). Three sub-categories emerge: **Nurse – Doctor/Surgeon Relations and Differences**, **Professional Relations within Nursing** and **Culture of Blame and Guilt**.

Nurse – Doctor/Surgeon Relations and Differences: This sub-category has two main themes. The first concerns the issue of teamwork between nurses and doctors. The data indicates that the working relationship between nurses and doctors is sometimes problematic.

- The working relationships between nurses and doctors varied depending on their respective grades and expertise
- The problem of doctors who are not “up to scratch”
- The issue of nurse-doctor/surgeon communications (doctors did not always keep documentation up-dated – doctors, particularly senior doctors and consultants were often unavailable when needed)

The second theme in this sub-category concerns differences between nurses and doctors/surgeons. The main differences between nurses and doctors emerging in this sub-category are philosophical, primarily ontological. Nurses and doctors appeared to view patients differently.

- Nurses spent more time with patients and got to know them better
- The nurse as patient’s advocate
- Doctors tended to relate to patients and see them in terms of their medical or surgical condition or diagnosis
- Nurses took a holistic view of patients
- Doctors might be willing to talk people into having surgery whereas nurses would take more time in discussing the situation. A particular concern of nurses was the patient’s quality of life
- The type of ethical decision-making doctors and nurses were involved in differed because doctors were formally responsible for a patient’s care and had primary legal responsibility

Professional Relations within Nursing: This sub-category is concerned with professional relations amongst nurses, an issue raised by a number of nurses. While professional relations between nurses were generally harmonious, this was not always necessarily so.

- Support or lack of it from nursing hierarchy – nurses identified incidents where they felt they had either been unsupported or supported by their nursing superiors
- The “unpopular nurse”
- The ill treatment of new nurses

Culture of Blame and Guilt: This sub-category is concerned with what appeared to be a culture of blame.

- Blaming others
- Nurses belittled themselves
- Feeling guilty

NURSING AND THE PATIENT

This category is concerned with a central theme in the data, that is, the relationship between the nurse and the patient. Three sub-categories emerge: **Philosophy of Care, The Professional Role of the Nurse** and **Nurse – Patient Relations**.

Philosophy of Care: This sub-category is concerned with the emergence of a nursing philosophy of care, the nature of which appeared to be holistic.

- Holistic philosophy – for nurses a patient’s “wellbeing” included concern for physical, psychological and social factors
- The importance of psychological and sociological care

The Professional Role of the Nurse: This sub-category is concerned with the way in which the nurse perceived the existence of a professional role and what that role entailed.

- Nurses indicated that they felt that they take on a role
- Assuming a professional role had its difficulties and created unhelpful barriers
- Assuming a professional role was useful in outlining what was expected of nurses.
The professional role of the nurse included:
Having a nursing philosophy of holistic care
Being sensitive and having empathy and insight into patient experiences
Assuming the role of patient advocate

Nurse – Patient Relations: This sub-category is concerned with the relationship between nurses and patients, which at times was a close one and had profound effects for both parties.

- Nurse-patient relations were generally harmonious but there are exceptions
- The nurse-patient relationship was a close one based on the fact that nurses had often cared for patients over a long period of time
- Nurses profoundly attempted to seek what was best for patients
- Nurses had sensitivity, empathy and sought insight into the patient’s experience
Nurses showed awareness of patient vulnerability
Nurses considered patient quality of life important
- Importance of truthfulness – disclosure and trust

Truthfulness was required on both a personal and professional level for the nurse
Nurses were concerned that information was, on occasions, either withheld from
patients or patients were deceived about their prognosis and diagnosis

APPENDIX 11

ILLUSTRATIVE EXAMPLE OF NARRATIVE ANALYSIS

The purpose of this illustrative example is to demonstrate how the narrative prose was translated into a poetic format and analysed. This particular example is Sally's account of an incident where she, while on night duty, experienced the sudden and totally unexpected death of a patient. The patient was young man who had only been admitted the evening before.

PROSE	POETRY	COMMENT
<p>S36-407 The incident where the nurse, while on night duty, found a young patient who had had a cardiac arrest – the resuscitation – the after effects</p> <p>C Ok, that's good. Fine, if I can get straight to the point really. It is a study into the ethical decision-making of nurses and while you have been working in cardio-thoracic care do you feel that you have faced situations which have been difficult, where ethical decision-making has been difficult?</p> <p>S Hmm, I suppose at the time if you are in difficult situation you don't realise you are making judgements and ethical decisions. Difficult situations, there have been many, as I have said. In particular the most difficult one I found was a particular incident on night duty. I was on with a sister, a newly qualified 'D' grade and a health care support worker. Sister went off sick about 3 o'clock in the morning and I was left in charge. The other two were doing the rounds to check all the patients. I was doing some admin work and I did the final round at about half past five in the morning and found a patient, (patient's age deleted), dead. He had been dead for over an hour I would say at least, over an hour. I tried to resuscitate him. It was much too late obviously. The</p>	<p>Hmm, I suppose at the time, if you are in a difficult situation you don't realise you are making judgements and ethical decisions. Difficult situations, there have been many. The most difficult one was a particular incident on night duty. I was on with a sister, a newly qualified 'D' grade and a health care support worker. Sister went off sick about 3 o'clock in the morning. I was left in charge. The other two were doing the rounds to check all the patients. I was doing some admin work and I did the final round at about half past five in the morning and found a [young] patient, dead. He had been dead for over an hour, at least, over an hour.</p>	<p>in difficult situations, you do not realise at the time, you are making ethical decisions</p> <p>description of the incident</p> <p>nurse was in charge of the ward on night duty and found a young patient dead</p> <p>the nurse tried</p>

<p>people I was on with were extremely stressed. I was stressed but they were extremely stressed to the point where they couldn't perform, couldn't function, couldn't do what I told them to do and felt afterwards that they hadn't performed properly as I did myself. Although thinking about it, as I did for some months after that, I realised all the things that I had done and actually I'd found personally had been right. But I blame myself, because I didn't know that he was dead or had been ill. They had a post-mortem and they found that he had a massive tear in his aorta. He had come in with an enlarged aorta, they sent him for emergency surgery, they didn't send any notes or X-rays. So they couldn't do any surgery on the night he came in and he died, I'd say, about eight hours later. So, but I felt that it was my fault. I felt that I should have been doing the checking, I shouldn't have left it to them. The health care support worker, I mean the qualified nurse was doing the check every half-an-hour really and I thought, you should have known. And I thought about it afterwards and I thought you obviously didn't check properly. But, I'd a lot of problems. I just couldn't get rid of the idea that it was my fault and it was nothing to do with them. Even though I thought that the registered nurse was accountable and should have known.</p>	<p>I tried to resuscitate him. It was much too late obviously. The people I was on with were extremely stressed.</p> <p>I was stressed but they were extremely stressed to the point where they couldn't function, couldn't do what I told them to do and felt afterwards they hadn't performed properly as I did myself. Although thinking about it, as I did for some months after, I realised all the things I had done I'd found personally had been right. But I blame myself, because I didn't know he was dead or had been ill. They had a post-mortem and found he had a massive tear in his aorta. He had come in with an enlarged aorta, they sent him for emergency surgery, they didn't send any notes or X-rays. So they couldn't do surgery on the night he came in and he died, about eight hours later. So, but I felt it was my fault. I felt that I should have been doing the checking, I shouldn't have left it to them. The qualified nurse was doing the check every half-an-hour and I thought, you should have known. And I thought about it afterwards, I thought you obviously didn't check properly.</p> <p>But, I'd a lot of problems. I just couldn't get rid of the idea it was my fault and it was nothing to do with them. Even though I thought the registered nurse was accountable and should have known.</p>	<p>to resuscitate the patient but it was too late</p> <p>extreme stress of the situation on the nurse and other staff</p> <p>long term personal effect on the nurse blaming self despite believing self to be right</p>
<p>C In what way did you think it was your fault then because you say that you felt that you should have...?</p>		<p>thinking that the other nurse had not checked properly</p>
<p>S I thought I should have known. It's not particularly reasonable or professional. I thought well there was a two-hour period where I was doing other things and I assumed that the patients would have been checked properly. I felt that I should have checked myself.</p>	<p>I thought I should have known. It's not particularly reasonable or professional. I thought there was a two-hour period where I was doing other things and I assumed that the patients would have been checked properly. I felt that I should have checked myself.</p>	<p>personal effect of the incident – blaming self and feeling at fault</p>
<p>C So, in what way was this situation for you an ethical situation?</p>		

<p>S I felt that I hadn't looked after the patient properly and hadn't given the proper care and felt that I hadn't supported the other people that I was with properly. I hadn't taken into consideration their age and very junior status. I can't remember all the right terms from doing ethics, to tell you the truth. (laughter) I'm trying frantically to think of something.</p> <p>C There is no right or wrong in terms and things.</p> <p>S Yea, I just felt it's like a dereliction of duty and I thought I didn't fulfil my role, I didn't support the people I was with and it was my fault he died, which took me a long time to come to terms with and then I decided no, it wasn't.</p> <p>C Do you still think that way now?</p> <p>S That it was my fault?</p> <p>C Yea</p> <p>S No, but I do, when I'm on night duty, I always do the checks myself.</p> <p>C You?</p> <p>S I always do the checks myself.</p> <p>C To what degree do you think that the circumstances you were in were difficult, because you said that the sister had gone off sick and you were on only with limited staff, a new 'D' grade and a health care support worker looking after...?</p> <p>S Thirty patients at the time. Yea, it had been a quiet night up until then. The other thing was I didn't realise how dire his diagnosis was when he came in. He had an enlarged aorta. He should have been for emergency surgery but I didn't really connect. I thought his situation was so dire that he warranted emergency surgery on that day. Why didn't they do it? Maybe it's not that bad. I didn't realise that the surgeon had just gone, "O well I haven't got the</p>	<p>I felt I hadn't looked after the patient properly and hadn't given the proper care and felt that I hadn't supported the other people I was with properly. I hadn't taken into consideration their age and very junior status. I can't remember all the right ethics terms.</p> <p>I just felt it's like a dereliction of duty. I thought I didn't fulfil my role, I didn't support the people I was with and it was my fault he died, which took me a long time to come to terms with and then I decided no, it wasn't.</p> <p>No, but [now], when I'm on night duty, I always do the checks myself.</p> <p>Thirty patients at the time. Yea, it had been a quiet night up until then. The other thing was I didn't realise how dire his diagnosis was when he came in. He had an enlarged aorta. He should have been for emergency surgery but I didn't really connect. I thought his situation was so dire he warranted emergency surgery on that day. Why didn't they do it?</p>	<p>the nurse felt she had failed to give proper care and support other staff</p> <p>feeling of failure regarding duty, professional role, supporting colleagues and patient's death - eventually coming to terms with incident and deciding self was not to blame</p> <p>not realising the seriousness of the patient's condition</p> <p>questioning</p>
---	--	--

notes, I'm going home."	Maybe it's not that bad.	and reflecting
C Is that what had happened?	I didn't realise that the surgeon had just gone,	on what could have been done
S Hmm, I thought why didn't they get them? Why didn't they have them brought for them in a taxi or why didn't they do something else?	"O well I haven't got the notes, I'm going home."	
C Was there any indication in terms of his clinical signs that he was potentially that unwell?	I thought, why didn't they get them? Why didn't they have them brought for them in a taxi or why didn't they do something else?	
S No he just had a deficit in blood pressure between both his arms, which is a sign. But apart from that he's up walking about saying, "I feel like a fraud, I'm quite well."	He just had a deficit in blood pressure between both his arms, which is a sign. But apart from that he's up walking about saying, "I feel like a fraud, I'm quite well."	
C So it must be a great shock when you found him and he had arrested.		
S Yea, yea I'm sure it took me six months and more before I could put it out of my head. I was waking my boyfriend up in the middle of the night. (laughter) He would say, "What are you doing?" "Nothing." I told him in the end and he said, "This is ridiculous."	I'm sure it took me six months and more before I could put it out of my head. I was waking my boyfriend up in the middle of the night. He would say, "What are you doing?" "Nothing." I told him in the end and he said, "This is ridiculous."	long term personal effect on the nurse – it took six months to get the incident out of her head
C Was there ethical difficulties do you feel around the situation not just for yourself but you mentioned like it was difficult for the staff to concentrate afterwards and for you to concentrate afterwards, after this had happened? Were there ethical difficulties around that?		
S What happened immediately afterwards, mornings can be particularly busy with pre-op patients and we got on with it. After the arrest and we had moved his body into the side-room and this sort of thing, we went on like automatic pilot and carried out our duties needs, which seemed to surprise everybody else. That worried me later on because I thought, "How sharp was I really?" Was I really thinking while I was giving people pre-meds? And getting them ready for theatre, they had heard the alarm buzzer going off, they were all very touched afterwards because it obviously	What happened immediately afterwards, mornings can be particularly busy with pre-op patients and we got on with it. After the arrest and we had moved his body into the side-room, we went on automatic pilot and carried out our duties, which seemed to surprise everybody else. That worried me later on because I thought, "How sharp was I really?" Was I really thinking while I was giving people pre-meds? And getting them ready for theatre, they had heard the alarm buzzer going off, they were all very touched afterwards because it obviously sounds like an	after the incident, trying to carry out nursing duties by continuing on automatic pilot being worried about the level of personal performance after the incident

<p>sounds like an emergency, it's so loud. And I thought then as well after that, "What sort of preparation was I giving these people, what sort of signals was I giving these people who were just about to go to surgery?" They were all terrified. And what did I look like? What sort of expression did I have? Because I know I can look grim when I stressed. And I thought "God." So the whole episode....</p>	<p>emergency, it's so loud. And I thought then as well, "What sort of preparation was I giving these people, what sort of signals was I giving these people who were just about to go to surgery?" They were all terrified. And what did I look like? What sort of expression did I have? Because I know I can look grim when I stressed.</p>	<p>concern for the welfare of patients and the level of personal performance</p>
<p>C One thing that strikes me was like trying to characterise this ethical situation you were in, it was an issue of questioning your own professional practice, and I was just wondering then when you were talking, the difficulty of carrying on afterwards must have been quite great. You say you were on "auto-pilot". Was there any offer of help?</p>	<p>And I thought, "God." So the whole episode....</p>	
<p>S Yea, when the day staff came on at half past seven they looked very shocked as well and were supportive. They came to talk to us, we were all in tears at this stage, and they said, "It's not your fault, da da da da." Which was a bit of a help at the time. But I found later on when I was thinking about the whole situation that I thought they were being really kind and they were probably thinking, "What were they doing all night, they've been sitting on their backsides by the desk, and why didn't they check the patients?" Yea, but I mean, the senior sister did come back later on and told us about the results of the post-mortem and said, you know, that it was absolutely hopeless, even if you had been there when he had arrested it wouldn't have made any difference. But I still just kept saying, "But I should have known, I should have known."</p>	<p>When the day staff came on at half past seven they looked very shocked as well and were supportive. They came to talk to us, we were all in tears at this stage, and they said, "It's not your fault, da da da da." Which was a bit of a help at the time. But I found later on when I was thinking about the whole situation I thought they were being really kind and they were probably thinking, "What were they doing all night, they've been sitting on their backsides by the desk, and why didn't they check the patients?" But, the senior sister did come back later on and told us about the results of the post-mortem and said, it was absolutely hopeless, even if you had been there when he had arrested it wouldn't have made any difference. But I still just kept saying, "But I should have known, I should have known."</p>	<p>helpful support from day staff</p> <p>thinking that the day staff were really saying one thing but thinking another</p>
<p>C Did those comments help when the senior sister came and told you that?</p>	<p>[Those comments] did [help] certainly, yea. I knew that she knew I was very stressed about it. I didn't take time off work.</p>	
<p>S O yea, it did certainly, yea. I knew that she knew that I was very stressed about it. I didn't take time off work or anything. I came straight back in but yea...</p>	<p>[Those comments] did [help] certainly, yea. I knew that she knew I was very stressed about it. I didn't take time off work.</p>	<p>support from the Senior Sister</p> <p>continuing to</p>

<p>C Why did you think that people still thought, "Well what were they doing during the night shift?"</p>	<p>I came straight back in.</p>	<p>work despite the distress</p>
<p>S If it had been me looking at it from the other side, I would have thought, "How could you not know?" I knew as soon as I looked at him. Other people must be thinking, "They didn't bother to check the patients." We all wrote statements and said what had happened, when, and yea they must think, "They didn't bother to check..." I know that from the other people involved, the 'D' grade, she still mentions it and talks about how terrible it was, it's an abiding memory.</p>	<p>If it had been me looking at it from the other side, I would have thought, "How could you not know?" I knew as soon as I looked at him. Other people must be thinking, "They didn't bother to check the patients." We all wrote statements and said what had happened. Yea they must think, "They didn't bother to check..." I know from the other people involved, the 'D' grade, she still mentions it and talks about how terrible it was, it's an abiding memory.</p>	<p>thinking that other nurses must be critical but were not saying</p> <p>the incident was terrible and is an abiding memory</p>
<p>C There is this issue isn't there that some of the things we go through as nurses are actually with us forever. They are very, very traumatic events.</p>		
<p>S Yea, it makes it really important, this thing about checking patients. I think what most people seem to think is to make sure that nobody is lying on the floor. If they are not lying on the floor they must be alright. And I've explained to people when they are going around to check what exactly they are looking for. I don't know whether they listened or whether I listened when other people told me, or did anybody ever tell me?</p>	<p>It makes it really important, checking patients. What most people seem to think is to make sure nobody is lying on the floor. If they are not lying on the floor they must be alright. And I've explained to people when they are going around to check what exactly they are looking for. I don't know whether they listened or whether I listened when other people told me, or did anybody ever tell me?</p>	<p>the importance of checking patients</p>
<p>C One thing you said then which I thought was quite interesting there was that like, you were concerned about the effect on other patients. Do you want to say just a little bit more about that because I am just wondering what happened, and how they were affected, and how then you felt, "How can we help the other patients go through this?" given that you had just gone through this awful experience yourself?</p>		
<p>S Hmm, I was trying to be as normal as possible. I don't know how normal I looked, as I said, or behaved. But I tried as I was going through explaining about pre-meds,</p>	<p>Hmm, I was trying to be as normal as possible. I don't know how normal I looked or behaved.</p>	<p>carrying on and trying to be as normal as possible</p>

<p>doing the pre-op checks and chatting to patients, but I really can't remember what I said. And as I say, because the arrest buzzer had gone off and it was going for a long time, that they all knew that something was going wrong. There were screens across the corridor, and moving beds about, and there were three other men in the bay with him as well, who heard obviously everything going on with the team coming as well. The other thing that happen which we all spoke to (the lead nurse) about was the fact that when the team came they decided after twenty minutes that there was no point and they were going to stop, and the anaesthetist started to show the junior house-officer how to do chest compressions.</p>	<p>But I tried as I was explaining about pre-meds, doing the pre-op checks and chatting to patients, but I can't remember what I said. And because the arrest buzzer had gone off and was going for a long time, they all knew something was going wrong. There were screens across the corridor, and moving beds about, and there were three other men in the bay with him as well, who heard everything going on with the team coming as well.</p>	<p>concern at the effect on other patients</p>
<p>C What after they had stopped resuscitation?</p>	<p>The other thing that happened, which we all spoke to [the lead nurse] about was the fact that when the team came they decided after twenty minutes there was no point and they were going to stop, and the anaesthetist started to show the junior house-officer how to do chest compressions.</p>	<p>another incident</p>
<p>S Hmm, and I snapped really at that point and I said, "I thought we'd finished, what are you doing?" And he said, "This man has been dead for five hours, core temperature is below 35, what are you talking about?"</p>	<p>I snapped really at that point and I said, "I thought we'd finished, what are you doing?" And he said, "This man has been dead for five hours, core temperature is below 35, what are you talking about?"</p>	<p>the anaesthetist started to use the body in order to teach chest compression</p>
<p>C Who said that?</p>		<p>nurse's emotional reaction</p>
<p>S The anaesthetist.</p>		
<p>C Said that to you?</p>		
<p>S Hmm, yea, and he seemed to think, "Well ok, maybe what I am doing is out of order." Maybe he didn't think it was out of order. I certainly did.</p>	<p>He seemed to think, "Well ok, maybe what I am doing is out of order." Maybe he didn't think it was out of order. I certainly did.</p>	
<p>C Why did you think it was out of order?</p>		
<p>S They didn't show respect for the person. Hmm, yea, he was talking about pull "it." He said, "Pull it over towards you." And then walked over. And I just thought, "God, that's appalling." So we did bring that up and we'd spoken to someone else about that and I said, "You should definite speak to someone and write it down and see if they can discuss that with the</p>	<p>They didn't show respect for the person. He was talking about pull "it." He said, "Pull it over towards you." And then walked over. I just thought, "God, that's appalling." So we did bring that up and we'd spoken to someone else about that and I said, "You should definitely speak</p>	<p>lack of respect for the patient who had died</p>

team.”	to someone and write it down and see if they can discuss that with the team.”	
C Did he stop once you raised the objection?		
S Yea, they just walked off.	Yea, [he did stop once I raised the objection] they just walked off.	
C So, with the other patients then, there were three patients in that bay. So they must have heard what went on there.		
S Yea, I just remember in the middle, the health care support worker, I just asked her to go and check the other patients and explain to them. Not to explain what was happening but to just to check and reassure them, make sure they were ok. There were people who were developing chest pain when they got stressed and so I thought, “What’s happening with the rest of them?” The three other men in the room could all get up and walk and they all left the room and went into the day room.	I just remember in the middle, the health care support worker, I just asked her to go and check the other patients and explain to them. Not to explain what was happening, but just to check and reassure them, make sure they were ok. There were people who were developing chest pain when they got stressed and so I thought, “What’s happening with the rest of them?” The three other men in the room Could all get up and walk and they all left the room and went into the day room.	having concern for the other patients during the incident
C What after it had finished or during?		beneficence and non-maleficence
S During, during, yea. They did that of their own volition actually and I asked the health care support worker to check them just to ... So she went and spoke to them and got them cups of tea.	They did that of their own volition So the health care support worker went and spoke to them and got them cups of tea.	
C How did they cope, do you know in the end, because it must have been terribly traumatic for them?		
S Hmm, one of the patients in that bay was due to go for surgery that day. He was an elderly man. So he must have said, “A young man, younger than me who had died.” They obviously know very quickly what’s happened. I didn’t actually even see him afterwards because I was days off after nights then. And I didn’t even see him after his surgery. So I don’t know, I can only guess how he felt. The other two patients just asked questions about what had happened, “Did he die?” And I thought, well yes it is important to tell them the truth and not to lie obviously. It was quite obvious what had happened. They	One of the patients in that bay was due to go for surgery that day. He was an elderly man. So he must have said, “A young man, younger than me who had died.” They obviously know very quickly what’s happened. I didn’t even see him afterwards because I was days off after nights then. And I didn’t even see him after his surgery. I can only guess how he felt. The other two patients just asked questions about what had happened, “Did he die?”	empathetic under-standing of the effect of the incident on another patient

<p>wanted to know what had happened and why, which I couldn't at that stage really tell them anything about, because I didn't know. I guessed but I wasn't really sure.</p> <p>C Did that present you with any difficulties, dealing with questions like that?</p> <p>S Yea, my first thought was... He may be dead, but it's still his business, it's confidentiality. It's his family's business. His family weren't even there at the time. But I thought I need to give some information. I wasn't going to go back and say, "O, the results of the post-mortem come through and this is what happened to this man." But I did explain that yea, he had died.</p> <p>C How did you decide how much to tell them in a way?</p> <p>S I thought that that's about as much as I could tell them really. Especially as his family hadn't been there. Some patients strike up a really close relationship and do know quite a lot about one another, and their families and their illnesses. They didn't know him particularly well. I just thought, "No it's confidential this information, what's happened and his condition." But I did need to tell them that he had died. I think maybe because they need to trust me and if they knew then they would know if I said, "No, he's very ill." Or, "I can't tell you." They wouldn't trust me.</p> <p>C So, it was important to be as honest as you can but within the bounds of confidentiality.</p> <p>S Yea, yea. Hmm.</p> <p>C Is there anything from an environmental or organisational aspect that would have been helpful to you during this whole incident that would have made ethical decision-making for you</p>	<p>And I thought, well yes it is important to tell them the truth and not to lie. It was quite obvious what had happened. They wanted to know what had happened and why, which I couldn't at that stage really tell them anything about, because I didn't know. I guessed, but I wasn't really sure.</p> <p>My first thought was, he may be dead, but it's still his business, it's confidentiality. It's his family's business. His family weren't even there at the time. But I thought I need to give some information. I wasn't going to go back and say, "O, the results of the post-mortem come through and this is what happened to this man." But I did explain that yea, he had died.</p> <p>I thought that's about as much as I could tell them, really. Especially as his family hadn't been there. Some patients strike up a really close relationship and do know quite a lot about one another, and their families and their illnesses. They didn't know him particularly well. I just thought, "No it's confidential this information, what's happened and his condition." But I did need to tell them he had died. I think maybe because they need to trust me and if they knew then they would know if I said, "No, he's very ill." Or, "I can't tell you." They wouldn't trust me.</p>	<p>veracity - importance of telling the truth about the patient's death to other patients</p> <p>importance of confidentiality</p> <p>considering the patient's family</p> <p>the need to give information to other patients</p> <p>recognising that patients develop close relationships amongst themselves</p> <p>need to tell other patients that he had died</p> <p>patients need to trust the nurse</p>
---	--	--

easier?		
S From an environmental do you mean ward layout really?		
C Anything from the way in which we organise things on the ward.		
S From the start he was away round the corner away from the desk. He should have been monitored and by the desk because his condition was critical. He should have had surgery that night. The conditions that you work in are all very cramped and if a patient becomes ill there's people two feet away who can hear everything that's going on. For the relatives as well we had to do the whole, and move someone out of a side-ward and move him in there for his family to come, his wife, to come see him afterwards. The duty manager said, "Well how are you going to do this?" I think she wanted me to prevent the rest of the ward knowing what had happened. I just had to close the doors, put a screen across and wheel the bloke in here. There was nothing else I can do. I didn't get very much support from the cardio-thoracic surgeon on call. He didn't come for twenty minutes after the arrest call went out. I assumed they were bleeped at the same time. Well actually, someone in the team bleeped the cardio-thoracic team and they just came and looked at him, shrugged their shoulders and walked off. I felt they should have stayed to speak to the relatives who were like, racing on their way to the hospital. They actually knew that he had died. The duty manager spoke to his wife.	From the start he was away round the corner away from the desk. He should have been monitored and by the desk because his condition was critical. He should have had surgery that night. The conditions that you work in are all very cramped and if a patient becomes ill there's people two feet away who can hear everything that's going on. For the relatives as well we had to move someone out of a side-ward and move him in there for his family, his wife, to see him afterwards. The duty manager said, "Well how are you going to do this?" I think she wanted me to prevent the rest of the ward knowing what had happened. I just had to close the doors, put a screen across and wheel the bloke in. There was nothing else I can do. I didn't get very much support from the cardio-thoracic surgeon on call. He didn't come for twenty minutes after the arrest call went out. I assumed they were bleeped at the same time.	environmental considerations patient should have been monitored and positioned near the nurses' desk bed-space areas are cramped facilities for relatives lack of support from the doctor on call
C On the phone?		
S Hmm, hmm.	Someone in the team bleeped the cardio-thoracic team and they just came and looked at him, shrugged their shoulders and walked off. I felt they should have stayed to speak to the relatives who were racing on their way to the hospital. They actually knew he had died before they got here. The duty manager spoke to his wife [on the phone].	feeling that cardio-thoracic team doctors should have stayed to talk to the relatives
C So they knew that he had died before...		

<p>S Before they got here. She asked. She suggested they come to the hospital now and she said, "Has he died?" So she said, "I'm sorry, yes he has." And she said, "Is this a joke?" I wish it was. But they apparently, when I had gone home after this, apparently his body was on the ward for quite a long time and his family were here for a long time before any of the surgeons came to speak to them.</p> <p>C So they were spoken to by members of the surgical team?</p> <p>S Eventually, yea.</p> <p>C Could you have been given support in any other way?</p> <p>S Hmm, the duty manager was quite supportive. She stayed for quite a while afterwards and made phone-calls to the beagle and things like that.</p> <p>C To?</p> <p>S To the beagle to come. I don't know what the name, the porter, to come to take this man away. And for some reason he stayed up here for ages. There was no one else here who I could call upon really. I thought afterwards there should have been someone more senior than me because I was a ...[junior nurse]... (grade deleted)... and hadn't even got the ALS.</p> <p>C The..?</p> <p>S The Advanced Life Support. I mean if he had been in a condition where he could have been resuscitated I would have been useless as well. There should have been someone there. I mean, it is still the case that people are in charge on nights and they are without certain qualifications. And when an arrest happens it's usually chaotic and panicky. I did ask about that later on and was told that I didn't really need it.</p> <p>C What was that sorry?</p>	<p>She asked. She suggested they come to the hospital now and she said, "Has he died?" So she said, "I'm sorry, yes he has." And she said, "Is this a joke?" I wish it was. Apparently, his body was on the ward for quite a long time and his family were here for a long time before any of the surgeons came to speak to them.</p> <p>The duty manager was quite supportive. She stayed for quite a while afterwards and made phone-calls to the porter and things like that.</p> <p>To come to take this man away. For some reason he stayed up here for ages. There was no one else here who I could call upon really. I thought afterwards there should have been someone more senior than me because I was a [junior nurse] and hadn't even got the Advanced Life Support.</p> <p>I mean, if he had been in a condition where he could have been resuscitated I would have been useless as well. There should have been someone there. It is still the case that people are in charge on nights and they are without certain qualifications. And when an arrest happens it's usually chaotic and panicky. I did ask about that later on and was told that I didn't really need it.</p>	<p>concern for the patient's relatives who knew he had died before they arrived at the hospital</p> <p>family waited a long time before doctors came to speak to them</p> <p>support from the Duty Manager</p> <p>concern at the lack of ALS qualifications</p>
--	---	---

<p>S The Advanced Life Support, or if I did want to do it I could to pay for it myself, which was three hundred quid and I thought, "I can't really afford that."</p>	<p>The Advanced Life Support, or if I did want to do it I could to pay for it myself, which was three hundred quid and I thought, "I can't really afford that."</p>	
<p>C Were you offered any sort of discussion afterward, after it had all happened because the way you have been talking about it, it has been a big thing. It has really affected you and the other nurses there. I'm just wondering would it have been helpful if someone talked you through it afterwards of did they?</p>		
<p>S Yea, the staff development sister who was here at the time actually came up that morning and spoke to us afterwards and said that if we wanted to come to speak to her later that she would be available to talk, but we didn't. We talked among ourselves and Quincy, who was a ... (deleted) ... grade, I spoke to him when he came on because he doesn't give you any nonsense. And if he thought you were wrong he would tell you, you were wrong, and he wouldn't try to flannel. So, but yea, it was really among ourselves, we talked it over and over and over (laughter) what had happened.</p>	<p>The staff development sister who was here at the time came up that morning and spoke to us afterwards and said that if we wanted to come to speak to her later she would be available to talk, but we didn't. We talked among ourselves and Quincy, I spoke to him when he came on because he doesn't give you any nonsense. And if he thought you were wrong he would tell you, you were wrong and he wouldn't try to flannel. It was really among ourselves, we talked it over and over and over what had happened.</p>	<p>support from the Staff Development Sister</p> <p>the importance of peer support and an honest appraisal of personal performance</p>
<p>C Was that useful?</p>		
<p>S It was eventually, yea. At the beginning we were all blaming ourselves and eventually sort of thought of various things that had happened and how we dealt with it.</p>	<p>At the beginning we were all blaming ourselves and eventually thought about various things that had happened and how we dealt with it.</p>	<p>at the beginning blaming self</p>
<p>C I think that's quite an interesting thing that you say there. Nurses, tend it seems to get support amongst themselves quite a bit.</p>		
<p>S Hmm, yea. We weren't offered any formal counselling or anything like that. I mean we could have sorted that out I suppose if we wanted to.</p>	<p>We weren't offered any formal counselling or anything like that. We could have sorted that out if we wanted to.</p>	<p>not being offered formal counselling</p>
<p>C Would you have wanted that?</p>		
<p>S Hmm, not at the time. But when I think about it now it disturbed me for about six months and it was really too long to be thinking about</p>	<p>When I think about it now it disturbed me for about six months and it was really too long to be thinking about that.</p>	<p>the incident disturbed the nurse for six months – this was too long –</p>

<p>that. And perhaps if I'd spoken to someone else about it and got someone else's point of view from outside the ward it may have helped.</p>	<p>And perhaps if I'd spoken to someone else about it and got someone else's point of view from outside the ward it may have helped.</p>	<p>some form of counselling may have helped</p>
<p>C Ok, before we move on is there anything else you want to say about that whole incident and all the issues around it, because I think there were a lot, ranging from what happened initially, to resuscitation, to dealing with the incident afterwards and your own reflections?</p>		
<p>S When I think about it, my thoughts about what had happened were very selfish as well. I kept thinking, "Me, me, me, what didn't I do and how much of this is my fault?" I'm just On that morning, how much time did I really take and what sort of face did I present to the other people who were still there?</p>	<p>When I think about it, my thoughts about what had happened were very selfish. I kept thinking, "Me, me, me, what didn't I do and how much of this is my fault?" On that morning how much time did I really take and what sort of face did I present to the other people who were still there?</p>	<p>thinking that her thoughts about the incident were selfish thoughts</p>
<p>C Was that selfish thoughts or was it thoughts geared towards trying to do your professional duty and having difficulties like having just experienced this?</p>		
<p>S Yea, I suppose so. I mean, your first thoughts as I say, what did I do? What did I do wrong? What should I have done?</p>	<p>I mean, your first thoughts, what did I do? What did I do wrong? What should I have done?</p>	
<p>C Are they selfish thoughts though or are they something else?</p>		
<p>S Probably selfish because I think, "Now I feel so bad about this, poor me." It's not like, "O poor you because you're still here and he isn't." And his wife, only married three months and it's dreadful. So, yea I did seem to feel quite sorry for myself.</p>	<p>Probably selfish because I think, "Now I feel so bad about this, poor me." It's not like, "O poor you because you're still here and he isn't." And his wife, only married three months and it's dreadful. So, yea I did seem to feel quite sorry for myself.</p>	
<p>C Is that a bad thing?</p>		
<p>S Hmm, I think it is probably natural. Yea, it's quite dramatic and stressful and yea.</p>	<p>Hmm, I think it is probably natural. Yea, it's quite dramatic and stressful</p>	<p>selfish thoughts are probably natural given that the event was dramatic</p>
<p>C Ok, shall we move on from this</p>		

incident? S Yea.	and yea.	and stressful
---------------------	----------	---------------

APPENDIX 12

DIAGRAM TO SHOW THE ETHICAL EXPERIENCES, REASONING AND DECISION-MAKING OF NURSES

